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 _____	06/05/2014

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 started on June 2, 2014 and completed on June 5, 2014, the sample included five (5) residents for complete review, eighteen (18) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 244 SS=B	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of Resident Council Meeting minutes, group interview, and staff interview, the facility failed to act on a grievance of the resident group regarding odors and soiled briefs in resident care areas for 3 of the past 4 months (March, April, and June 2014). Failure to remove soiled briefs from resident rooms resulted in odors offensive to residents in the resident care areas. Findings include: - Review of the Resident Council Meeting minutes occurred on 06/03/14. The minutes identified the following regarding odors in the resident care areas:	F 244	**F-0244 Listen/Act on Group Grievance/Recommendation** 1. CRA's reminded of importance of keeping rooms clean and free of odor. At all resident council meetings a Nurse Manager will be present to address concerns right away and follow-up and see that changes are made on new tracking sheet 2. All residents are at risk to odors in room and hallway 3. Education for all staff on 7/1/14 and 7/8/14 on the importance of taking out garbage to prevent odors 4. Room check QA has been started between shifts. Also 10 rooms will be QA weekly for 1 month then monthly for 3 months then quarterly till resolved. Will be monitored at monthly QA meeting Nurse Manager 5. Date of completion ~~7/4/14~~ 7/10/14 Tc. C. MacArthy DON ~~7/4/14~~ 7/8/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Rustamson | TITLE: CEO | (X6) DATE: 7-3-14

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

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F 244	Continued From page 1 *03/03/14 - "One member is not happy with the odor that comes out of some of the other resident's room [sic]. Particularly the residents that use pads. Pads should be taken out of rooms." *04/07/14 - "Residents on 2nd [floor] feel CNA's [certified nursing assistants] should be taking soiled briefs right out of the rooms because of the odors. This is the same concern as last month." - During the resident group interview, on 06/03/14 at 1:00 p.m., with residents the facility identified as interviewable, 3 of 10 residents (Resident A, D, and E) reported odors in their resident care areas attributed to soiled briefs. These residents reported the odors were improved in May 2014. - During the initial tour, on 06/02/14 at 11:00 a.m., observation identified odors of ammonia in the area of a second floor resident room. - During the facility environmental tour, on 06/03/14 at 2:30 p.m., observation identified a strong odor of ammonia in the same resident bathroom identified during the initial tour and several briefs in the garbage can. A facility maintenance management staff member (#10) present during the tour confirmed the odor and briefs in the garbage. The staff member (#10) confirmed facility staff should remove the soiled briefs from the room when assisting residents and reported the facility did have difficulty with staff consistently removing soiled briefs.	F 244	**F-0244 Listen/Act on Group Grievance/Recommendation** 1. CRA's reminded of importance of keeping rooms clean and free of odor. At all resident council meetings a Nurse Manager will be present to address concerns right away and follow-up and see that changes are made on new tracking sheet 2. All residents are at risk to odors in room and hallway 3. Education for all staff on 7/1/14 and 7/8/14 on the importance of taking out garbage to prevent odors 4. Room check QA has been started between shifts. Also 10 rooms will be QA weekly for 1 month then monthly for 3 months then quarterly till resolved. Will be monitored at monthly QA meeting 5. Date of completion 7/4/14	7/4/14
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 2 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide reasonable accommodations of individual needs for 1 of 1 sampled resident (Resident #13) observed in a geriatric chair (geri chair) (a high back wheelchair with a foot ledge). Failure to provide lower extremity support while seated in a geri chair may result in reduced range of motion, unnecessary fatigue, and pain. Findings include: Review of the facility policy titled "Wheelchair Positioning" occurred on 06/05/14. This undated policy, stated, "Normal Sitting Postural Alignment . . . 1. Feet rest flat on a support. . . ." Observation showed Resident #13 seated upright in a geri chair with her feet dangling approximately six to eight inches from the floor at the following times: * 06/02/14 at 5:25 p.m. * 06/03/14 at 8:20 a.m., 9:25 a. m., 11:50 a.m., and 4:30 p.m. During an interview on 06/03/14 at 2:30 p.m., an administrative nurse (#6) stated she was not aware Resident #13 sat in a geri chair. This nurse further stated staff failed to complete a seating and positioning assessment.	F 246	**F-0246 Reasonable Accommodation Of Needs/Preferences** 1. Wheelchair assessment was completed on resident #13. OT was also notified and changes have been made for better positioning 2. All residents that are in need of a wheelchair positioning 3. Policy has been reviewed/revised, anytime a wheelchair is ~~change~~ switched a 3 day nursing assessment will be completed OT will be notified and an order will be received for them to assess after assessment is completed. 4. Residents with a need for wheelchair positioning will be assessed for 3 days and then OT will follow-up. QA will be done monthly for 3months then quarterly till resolved. Will be monitored at monthly QA meeting 5. Date of completetion ~~7/4/14~~ T.C 7/10/14 C. McCarthy Dow D Nurse manager will do QA started on 6/27/14 ~~7/4/14~~ 7/8/14	

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F 246	Continued From page 3 During an interview on 06/04/14 at 10:10 a.m., an occupational therapist (OT) (#7) stated nursing staff obtained a geri chair for Resident #13 on 04/29/14. She did not receive an order for a seating and positioning assessment. This OT stated she would suggest supporting the resident's feet when the geri chair is not reclined.	F 246	**F-0253 Housekeeping & Maintenance Services**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure housekeeping and maintenance services to maintain an odor free environment in 1 of 5 resident care areas (Circle of Life) on 4 of 4 days of survey (June 02-06, 2014). Failure to identify an odor in the hall at the Circle of Life and investigate the source resulted in an uncomfortable atmosphere for residents, visitors, and staff. Findings include: During the initial facility tour, on 06/02/14 at 11:00 a.m., observation in the hall outside the Circle of Life identified a strong odor similar to sewer gas. A check of the resident bathroom exhaust vents in the Circle of Life showed the exhaust failed to hold a tissue paper placed to the vent, an indication of possible lack of exhaust ventilation. This failure occurred in the resident rooms 1401	F 253	1. The exhaust fan was repaired on 6/4 /2014 by GR controls. This will provide air exchange to the hallway outside the Circle of Life Cottage. 2. Safety committee member doing the interior Q.A. walk through will follow the Q.A. inspection report that identifies odor throughout the facility. If odor is reported Environmental Service will investigate and correct problem area. 3. All exhaust fans will be put on a PM for monitoring appropriate operation. Training and Education will be completed on July 1st and 8th on identifying odors. 4. Environment Service Department will monitor all exhaust fans by performing a QA on a Quarterly basis and document the inspection period. 5. Corrected by: T.C. 7/10/14 R. McCarthy Dir ~~6/4/14~~ 7/8/14	

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F 253	Continued From page 4 through 1406 and the rest room immediately inside the Circle of Life doors. Random observations on 06/02/14 and 06/03/14 continued to demonstrate the odor and the lack of exhaust in the Circle of Life. During the facility environmental tour, on 06/03/14 at 2:30 p.m., a facility maintenance management staff member (#10) confirmed the odor and the lack of exhaust in the resident bathrooms of rooms 1401 through 1406, the rest room, and the hallway outside the Circle of Life. On the morning of 06/04/14, a facility maintenance management staff member (#10) stated the facility staff checked the exhaust system on 05/23/14 (10 days earlier) and found no problems. This staff member (#10) stated is unknown when the Circle of Life exhaust system malfunction occurred. Observation on 06/05/14, showed the odor remained in the hall outside the Circle of Life. Failure of facility staff to identify the strong odor delayed the repair of the malfunctioning equipment and resulted in continued strong odor.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 281		

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 5 review of professional literature, the facility failed to follow professional standards of care including accurately transcribing physician orders and ensuring medication received from pharmacy identified the correct dose of medication for 1 of 1 sampled resident (Resident #2) receiving monthly IM (intramuscular) injections over the past year. Failure to follow professional standards during receipt of a physician order for a medication and failure to identify an abnormally high dose of a medication placed the resident at risk for adverse health effects and has the potential to increase the risk of medication errors. Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, Fourth Edition, 2001, Lippencott, page 578 stated, "Checking the Medication Order . . . Increasingly numbers of healthcare facilities are computerizing patient records, including medication records. The nurse is responsible for checking that the transcription of the medication order is correct by comparing it with the original order. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 842, stated, ". . . The nurse should always question the primary care provider about any order that is ambiguous, unusual (e.g., an abnormally high dosage of a medication), . . . " Page 846 stated,". . . Nurses who administer medications are responsible for their own actions. . . . Be knowledgeable about the medications you administer . . . Look up the necessary information if you are not familiar with the medication. . . ." Review of Resident #2's medical record occurred	F 281	**F-0281 Services Provided Meet Professional Standards** 1. Resident #2 Cynocobalamin order has been transcribed correctly. 2. All residents on IM drug regimen have potential to be at risk 3. Their Medication Administration policy has been reviewed/revised on the 5 rights of medication administration for IM injections given by nurse. Education was done on 7/1/14. 4. We will review 10 resident chart QA that will be done by nurse managers and Medical records will also do a monthly Audit on MARS and transcription to ensure transcription is done correctly. Will be monitored at monthly QA meeting 5. Date of completion ~~7/4/14~~ 7/8/14 QA start on 6/30/14 ~~7/4/14~~ T.C. 7/10/14 Kj McCarthy DON	

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F 281	Continued From page 5	F 281		

review of professional literature, the facility failed to follow professional standards of care including accurately transcribing physician orders and ensuring medication received from pharmacy identified the correct dose of medication for 1 of 1 sampled resident (Resident #2) receiving monthly IM (intramuscular) injections over the past year. Failure to follow professional standards during receipt of a physician order for a medication and failure to identify an abnormally high dose of a medication placed the resident at risk for adverse health effects and has the potential to increase the risk of medication errors.

Findings include:

Taylor, Lillis, and LeMone, Fundamentals of Nursing, Fourth Edition, 2001, Lippencott, page 578 stated, "Checking the Medication Order . . . Increasingly numbers of healthcare facilities are computerizing patient records, including medication records. The nurse is responsible for checking that the transcription of the medication order is correct by comparing it with the original order. . . ."

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Review of Resident #2's medical record occurred

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F 281	Continued From page 6 June 2-4, 2014. Diagnoses included B complex deficiencies (vitamin B deficiencies). A physician progress note, dated 04/17/14, stated, "cyanocobalamin (Vitamin B-12): inject 1,000 mcg [micrograms] IM 1 time a month." The May 23, 2014 MAR (medication administration record) stated "cyanocobalamin 1,000 mg [milligrams] IM every month." 1,000 mg is equal to 1,000,000 mcg; which was 1,000 times the dose ordered. During an interview on 06/04/14 at 8:30 a.m., an administrative nurse (#6) stated that pharmacist drug regimen review forms are filed in the resident's medical record only if a concern is identified. Resident #2's medical record failed to include a pharmacist report regarding cyanocobalamin. Failure of facility staff to ensure the dose of cyanocobalamin was appropriate placed the resident at risk and potentially increased the risk of medication errors.	F 281		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Council Meeting minutes, and group,	F 318		

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F 318	Continued From page 7 resident, and staff interviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 6 of 10 sampled residents (Resident #4, #5, #17, #18, # 19, and #21) with orders for restorative therapy (RT). Failure of facility staff to provide the therapy program as care planned has the potential for Resident #4, #5, #17, #18, # 19, and #21 to experience reduced mobility and increased pain/discomfort. Findings include: The facility failed to provide a policy and procedure specific to restorative therapy services when requested at the time of this survey. - Review of the Resident Council Meeting minutes, dated 03/03/14, 04/07/14, and 05/05/14, identified the following concerns regarding "Therapy:" *03/03/14 - "1st floor therapy still not getting done." *04/07/14 - "Residents on 1st floor not getting restorative therapies. When the CNA [certified nursing assistant] comes to do them, the CNA will state she/he has to go out onto the floor and can't do it. - A resident on 3rd floor says the CNA has said she/he 'doesn't have time to do therapy among other duties' to resident in response to resident asking about restorative therapy." *05/05/14 - "Residents still not getting restorative therapies from CNA's. Problem has not been better for a few months." - During the resident group interview, on 06/03/14 at 1:00 p.m., with residents the facility identified	F 318	**F-0318 Increase/Prevent Decrease In Range Of Motion.** 1. Restorative program has been re-evaluated and updated, CRA were re-educated on restorative program by PT/OT. Also proper documentation and CRA charting is being changed 7/1/14 7/8/14 2. All resident's on a restorative program 3. Job duties have been redone to ensure routine restorative programs are being completed. Also education has been done on proper techniques for program and proper documentation 7/1/14 7/8/14 education 4. All residents who are on a restorative program, 10 will be chosen and QA will be done weekly for one month then monthly for 3 months then quarterly till resolved and will be discussed at QA monthly meeting MDS coordinator do QA start on 7/14/14 5 Date of completion. ~~7/4/14~~ 7/10/14 T.C. K. McCarthy DON	~~7/4/14~~ 7/8/14

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as interviewable, 3 of 10 residents reported the facility staff should be providing routine exercise programs for them but they are not receiving the exercises. The residents (A, B, and C) reported they have not received exercise programs on a regular basis for several months and confirmed the concerns identified in the March through May 2014 Resident Council Meeting minutes. The residents reported no improvement after the residents voiced their concerns at the Resident Council meetings.

- Review of Resident #17's medical record occurred on June 04-05, 2014. Diagnoses included muscle weakness, fatigue, spinal stenosis, osteoarthrosis, and pain. The quarterly Minimum Data Set (MDS), dated 03/05/14, identified intact cognition, required limited-to-extensive assistance for all Activities of Daily Living (ADLs), and functional impairment of upper extremities.

The care plan, initiated 03/24/14, identified, ". . . Restorative program * AAROM [active assistive range of motion]: *Strengthening. . . . Restorative nurse to monitor progress and make changes prn [as needed], Document quarterly, Provide AROM [active range of motion] and AAROM as outlined on kiosk. [computer terminal] . . ."

Resident #17's restorative therapy program identified, "3 Days/Wk [week]: AAROM: Left Shoulder flex [flexion]/ext [extend]/abd [abduct]/add [adduct] x [times]10, Right Shoulder flex/ext with 2# [pound] wrist wt. [weight] x 10, Both sides: Elbow flex/ext with 2# wt. and dowel x 15, Forearm supination [inward rotation]/pronation [rotation of the hand so the palm is facing downward] with 1# wrist wt x 10,

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Wrist flex/ext with 1# wrist wt. x 10, Tricep [muscle of the upper arm] Press with red t-band [thera-band] x 15, Theraputty [hand putty] or stringing foam pieces or beads - can do independently, Lower body: 3 sets of 10: Seated: Hip flex with 4# wt. Knee flex with green thera-band, 2 sets of 10 with 4WW [four wheeled walker]: Marching (High Stepping), Squats, Heel raises."

The "MDS Coordinator Notes" identified the following:
* 06/18/13, ". . . Res. [Resident] [#17] is on restorative program for ROM exercises and ambulating and dressing. Has decreased ROM in left shoulder which makes it difficult so exercises are only performed to resident's tolerance. . . ."
* 09/11/13, ". . . Res. is on restorative program for ROM exercises. Has decreased ROM in left shoulder which makes it difficult so exercises are only performed to resident's tolerance. . . ."
* 12/12/13, ". . . Res. is on restorative program for ROM exercises. Res. has been refusing r/t [related to] pain but will continue to offer."

A "Care Conference Notes," dated 05/29/14, identified, ". . . Resident [#17] states having concerns with not getting therapy. Resident was offered therapy by the cna helper and resident did not like this lady doing her therapy, so it was recently changed to the med [medication] aid [sic]. Resident states the med aid [sic] has not been in to ask about therapy in 2 weeks. . . ."

The "Documentation Survey Reports" identified the following:
* May 01-31, 2014: one 15 minute RT session, one "non-applicable" RT session, one occasion where staff documented Resident #17 as

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unavailable, and two refusals.
* June 01-05, 2014: one 20 minute RT session.

Resident #17 received a total of 15 minutes of RT during the month of May, and 20 minutes during the first week of June. According to her RT program, she should have been seen 13-14 times in May and twice in June.

During an interview on 06/04/14 at 10:20 a.m., Resident #17 stated, "Three weeks I was without [RT]. They just started [RT] yesterday."

- Observation of Resident #4 on all days of survey showed her lying in bed or sitting in her wheelchair with a cone in the palm of her left hand.

Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, quadriplegia, scoliosis, osteoporosis, and pain. The quarterly MDS, dated 03/28/14, identified severely impaired cognition, required total assistance for all ADLs, and functional impairment of both upper and lower extremities.

The care plan, initiated 12/28/12, identified, ". . . I have a hand cone in my left hand. . . . I am on [a] maintenance exercise program for passive ROM. . . . Restorative nurse to monitor progress and chart quarterly. Make changes prn, CRA's [certified resident assistants] to perform passive ROM exercises as outline on kiosk 3 days per week. . . ."

Resident #4's restorative therapy [RT] program identified, "3 PM's [afternoons]/Wk [week] T [Tuesday], TH [Thursday], SA [Saturday]: PROM [passive range of motion]-AAROM all motions x

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10: Shoulder Ext/Flex/Abd/Add/Int [internal] & [and] Ext [external] Rotation, Elbow Flex/Ext, Wrist Flex/Ext, Fingers and thumbs Flex/Ext, Gentle PROM-gentle partial ROM only; once resistance is felt, STOP. Hip Abd/Add/Flex/Ext/Int & Ext Roation [sic], Knee Flex/Ext, Ankle Flex/Ext."

The "MDS Coordinator Notes," dated 07/09/13, 10/03/13, 01/09/14, and 04/04/14, identified, ". . . Res [#4] on restorative/maintenance program for PROM exercises. . . ."

The "Documentation Survey Reports" identified the following:
* May 01-31, 2014: one 5 minute RT session, one 10 minute RT session, nine "non-applicable" RT sessions, and one refusal.
* June 01-05, 2014: one "non-applicable" RT session.

Resident #4 received a total of 15 minutes of RT during the month of May, and zero minutes during the first week of June. According to her RT program, she should have been seen 14 times in May and twice in June.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, muscle weakness, osteoarthrosis, osteoporosis, and pain. The quarterly MDS, dated 04/30/14, identified moderately impaired cognition.

The care plan, initiated 05/05/13, identified, "Restorative Program *ROM. . . . Restorative nurse to chart progress quarterly and make changes prn, Provide AROM as outlined on kiosk. . . ."

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Resident #5's restorative therapy program identified, "3 Days/Wk, T, TH, SA, Shoulder abd/add with green t-band x 15, Elbow flex/ext with green t-band x 20, Saratoga [cycle] x 10-15 minutes, Theraputty, Seated: 3 sets x 10, Hip flex/Knee ext with 4# wts, Hip ext/abd and Knee flex with green t-band."

The "MDS Coordinator Notes" identified the following:
* 05/16/13, ". . . Continues on restorative program for ROM exercises. Tolerating well and no changes to be made at this time. . . ."
* 10/31/13, ". . . Continues on restorative program for ROM exercises. Frequently refuses or is attending an activity but will continue to offer. . . ."
* 02/10/14 and 05/02/14, ". . . Continues on restorative program for ROM exercises. Frequently refuses or is not available but will continue to offer. . . ."

A "Care Conference Note," dated 05/02/14, identified, ". . . Resident [#5] would like more excersize [sic], has a restorative program, but resident says she has not been getting. . . . Will have CRAs do more restorative therapy . . ."

The "Documentation Survey Reports" identified the following:
* May 01-31, 2014: six 15 minute RT sessions and one "non-applicable" RT session.
* June 01-05, 2014: one zero minute RT session and one refusal.

Resident #5 received a total of 1 hour 30 minutes of RT during the month of May, and zero minutes during the first week of June. According to her RT program, she should have been seen 14 times in

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F 318	Continued From page 13 May and twice in June. - Review of Resident #18's medical record occurred on June 04-05, 2014. Diagnoses included Alzheimer's disease and dementia. The quarterly MDS, dated 03/19/14, identified moderately impaired cognition. The care plan, initiated 03/19/13, identified, ". . . Restorative Program *AROM. . . . Provide AROM as outlined on kiosk, Restorative nurse to monitor progress and document quarterly. Make changes prn. . . ." Resident #18's restorative therapy program identified, "3 Days/wk, M [Monday], W [Wednesday], F [Friday], Should [sic] flex/ext/abd/add/internal and ext. rotation with cane and 2# wt. x 10, Elbow flex/ext with cane and 3# wt. x 15, Chest Press with cane and 1# wt. x 10, Tricep press with blue t-band x 15, Handgripper 15# x 25, Saratoga 5-10 min. [minutes], Theraputty." The "MDS Coordinator Notes," dated 09/30/13, 12/24/13, and 03/31/14, identified, ". . . Continues of [sic] restorative program for ROM. No changes to be made at this time. Res. is often busy with activities during the day but will continue to offer exercises when res. available. Will continue to monitor . . ." The "Documentation Survey Reports" identified the following: * May 01-31, 2014: three zero minute RT sessions, one 10 minute RT session, one 20 minute RT session, one 25 minute RT session, twelve "non-applicable" RT sessions, and four occasions where staff documented Resident #18	F 318		

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as unavailable.
* June 01-05, 2014: three "non-applicable" RT sessions.

Resident #18 received a total of 55 minutes of RT during the month of May, and zero minutes during the first week of June. According to her RT program, she should have been seen 13 times in May and twice in June.

- Review of Resident #19's medical record occurred on 06/04/14. Current diagnoses included chronic pain, osteoarthritis, and restless leg syndrome. The quarterly MDS, dated 03/04/14, identified the resident required extensive assistance with transfers, dressing, and toileting. Resident #19's care plan identified the resident required active/passive ROM.

Resident #19's restorative therapy program identified the following:
". . . 6 Days/wk (B) [bilateral] U/E [upper extremity] AAROM all motions x10. Elbow flex/ext 1# wrist or cane x10. Tricep press red T-band x15. Hand gripper 10# x20. Theraputty or cone stacking. (B) L/E PROM hip flex/ext, abd/add, knee flex/ext, ankle plant/dorsal 5-10 reps. . . ."

The "Documentation Survey Report" identified the following:
* May 01-31, 2014: five RT sessions, one resident refusal, and one resident not available.

According to Resident #19's RT program the resident should receive RT services six times a week.

- Review of Resident #21's medical record occurred June 04-05, 2014. Diagnoses included

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dislocated right hip, gait abnormality, osteoarthrosis and generalized pain. The quarterly MDS, dated 03/24/14, identified she required extensive assistance for almost all ADLs, and functional impairment on one side of lower extremities.

The care plan, initiated 10/25/13, identified, "Restorative program *AROM. . . . Restorative nurse to document progress quarterly and make changes prn. Assist with AROM as outlined on kiosk."

Resident #21's restorative therapy program identified, "3 days/wk: M,W,F: Seated: 3 sets of 10 (Left lower extremity only): hip flex with 4# wts, Hip ext with green t-band, knee flex with green t-band, knee ext with 4# wts."

The MDS Coordinator Notes, dated 12/27/13 and 04/01/14, identified ". . . Res continues on restorative program for ROM exercises. . . ."

The "Documentation Survey Reports" identified the following:
* May 01-31, 2014: two fifteen minute RT sessions, and one "non-applicable" RT session.
* June 01-05, 2014: one zero minutes RT session.

Resident #21 received a total of 30 minutes of therapy during the month of May, and zero minutes during the first week of June.

According to her RT program, she should have received therapy 13-to-14 times in May and twice in June.

During interview on 06/02/14 at 4:00 p.m., a

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F 318	Continued From page 16 licensed nurse (#9) reported restorative therapy staff may be assigned to nursing staff duties when the facility is short staffed. At these times, facility staff may not provide restorative therapy services. During an interview on 06/03/14 at 4:50 p.m., a managerial nurse (#8) confirmed the restorative therapy programs are not done consistently and when the facility is short staffed, the restorative aides get pulled to work on the floors.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #9) identified with a burn received the care and services necessary to attain the highest degree of safety possible while drinking hot liquids. Failure to provide assistance with hot liquids at a safe temperature resulted in Resident #9 sustaining burns on his body and caused unnecessary discomfort and pain. Failure of the facility to implement a system to monitor the temperature of the hot water dispensing machines used by residents has the potential to result in additional burns to residents who drink	F 323		

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F 323	Continued From page 17 hot liquids. Findings include: Review of Resident #9's medical record occurred on June 2-5, 2014. Medical diagnoses included Alzheimer's dementia and vision loss. At the time Resident #9 sustained a burn, the Minimum Data Set (MDS), dated 10/02/13, identified severely impaired vision, moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of nine, and requiring extensive assistance of one person with eating. Review of Resident #9's progress notes stated the following: *08/29/13 at 1:48 p.m. - ". . . friction-skin rub under L) [left] thigh Cause of skin condition: unknown . . . no bleeding noted, no drainage, 3 cm [centimeters] in length . . . applied Bacitracin . . ." *08/30/13 at 10:01 a.m. - ". . . Burn . . . Resident states that he spilled hot tea on himself a few days ago' . . . Wound is C-shaped. No drainage. Resident denies pain at rest but burn is tender to touch. Wound bed is bright red. Peeling skin noted at wound edges . . . Resident going to [name of the clinic] to be evaluated this afternoon" *09/06/13 at 11:23 - ". . . Burn . . . Resident spilled hot tea on himself on 08/28/13 . . . . Edges of burn are pink. Burn wound bed is yellow in color. Small amount of purulent drainage noted. No odor . . . Resident denies pain while at rest but dressing change procedure was painful . . . Silvadene cream [antibiotic ointment] applied. Wound covered . . . Resident given scheduled pain medications . . ." *09/13/13 at 2:39 p.m. - " . . . Periwound area	F 323	**F-0323 Free of Accident Hazards/Supervision/Devices** 1. Corrective action has taken place for resident (#9) to prevent a future burn. Also, coffee/hot water machines have been turned down to provide a hot liquid of no greater than 150-155°F by the manufacture. 2. All residents identified with functional disabilities are at risk of burn. 3. Written Nutrition Risk Assessment and Policy have been modified. A list of all residents with adaptive equipment continues to be provided in all dining areas. Staff was educated on 07/01/14 and 07/08/14. Coffee/hot water machines have been turned down to provide a hot liquid of no greater than 150-155°F by the manufacture. 4. To monitor the performance of the corrective action taken, a form titled "Dinning Checklist" will be used to ensure all areas of prevention are being met. These quality assurance checks will be completed weekly for one month, monthly for three months, and then quarterly. Coffee/hot water temperatures will be monitored on a weekly basis. Data collected from these quality assurance checks will be discussed monthly at Quality Assurance meetings. 5. Corrective action was completed 7/08/14.	7/8/14

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F 323	Continued From page 18 slightly pink. Wound itself is yellow in color and scabbed over with no drainage noted. Res [resident] does continue to c/o [complain of] pain to this area . . ." *09/13/13 at 10:41 p.m. - " . . . Burn . . . periwound reddened, wound bed yellow with scant amount of drainage noted . . . Silvadene ointment applied, area covered . . . and wrapped . . ." *09/20/13 at 5:15 p.m. - ". . . Noted burn measures 1.1 by 3 is whitish color in center and slightly redish [sic] surrounding burn. Res continues to c/o discomfort with touch and dressing changed. No drainage noted . . ." *09/27/13 at 11:25 a.m. - ". . . Burn measures 3.2 cm x 0.8 cm. Small amount of yellow drainage present on old dressing. Resident does complain of a little tenderness during his treatment but states that it's not as painful anymore . . ." *10/04/13 at 4:00 p.m. - ". . . Noted area to back of lt thigh is 1.4 by 0.6 area is scabbed with a light color scab and res stated that it must be healed as he felt no pain to area . . ." *10/06/13 at 1:03 p.m. - ". . . Posterior upper (L) thigh, dark red discoloration to periwound, wound with scab intact, no drainage noted . . ." *10/11/13 at 4:48 p.m. - ". . . area is scabbed measuring 0.8 by 0.4. Noted scar tissue surrounding wound. Res denies pain . . ." *10/19/13 12:53 a.m. - ". . . (L) upper posterior thigh, area healed with a scar present. Area resolved, order received to continue Silvadene until f/u [follow up] appt [appointment] . . ." Resident #9's current care plan stated a problem: ". . . Hx [history] of burn to upper posterior L thigh . . ." and approaches: ". . . Allow resident to consume liquids per self . . . Identify food items using the clock method. . . ."	F 323		

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F 323	Continued From page 19 Observation on 06/03/14 at 1:40 p.m. showed Resident #9 seated independently in the dining room for siesta snack. Interview of a dietary aide (#1) identified the resident sometimes asks for hot tea and receives the tea in an uncovered plastic coffee cup. Observation on 06/04/14 at 7:50 a.m. showed Resident #9 seated independently in the dining room for breakfast. A dietary aide (#2) obtained water from a dispenser on the coffee machine and served Resident #9 hot chocolate in an uncovered plastic coffee cup. Interview of the dietary aide (#2) identified she serves him hot chocolate the same way each day. This surveyor obtained a cup of water from the dispenser, immediately checked the temperature, and found the temperature measured 166.7 degrees Fahrenheit. During an interview on 06/04/14 at 8:45 a.m., an administrative dietary staff member (#3) stated she was aware of Resident #9's burn in October 2013 and that Resident #9 "falls asleep with cup in hand"; however, facility staff did not implement interventions to prevent further burns after the incident in October 2013. The facility staff did, however, implement the use of a cup cover on Resident #9's hot liquid cups as of 06/04/2014. During an interview on 06/04/14 at 8:55 a.m., an administrative dietary staff member (#4) stated she was unaware of Resident #9's burn. This staff member stated dietary staff had never completed monitoring of hot water temperatures from the coffee machines and could not identify a target temperature for hot water.	F 323		

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F 323	Continued From page 20 During an interview on 06/04/14 at 3:15 p.m., a representative for the coffee machine company (#5) stated each machine is set at 180 degrees Fahrenheit. The representative (#5) also indicated he adjusted the hot water temp down to 155 degrees F. for all facility dispensers on 06/04/2014. Failure to implement a systemic process to monitor and check the temperature of the coffee/hot water dispensing machines continue to place Resident #9 and all residents independent who consumed hot liquids at risk of sustaining burns.	F 323		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for residents, staff, and the public regarding the lack of an anti-siphon device on hoses in a mechanical room on 1 of 5 resident care units (First Floor). Failure to include an anti-siphon device on two hoses attached to a spout and laying in a mop sink placed the residents, staff, and the community at risk of exposure to contamination of the potable water supply in the event of sewage backup and loss of water pressure.	F 465		

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F 465	Continued From page 21 Findings include: Observation during the facility environmental tour, on 06/03/14 at 2:30 p.m., in the mechanical room across the hall from the dining room on the First Floor resident care area, identified two hoses attached to a four hose adapter attached to a sink spout. The ends of the two hoses rested in the bottom of a mop sink. The sink spout and the four hose adapter lacked anti-siphon devices. A facility maintenance management staff member (#10), present during the observation, confirmed the spout and adapter lacked anti-siphon devices and the spout should have an anti-siphon device.	F 465	**F-0465 Safe/Functional Sanitary/Comfortable Environ.** 1. Anti-siphon device was installed in the sink in the mechanical room on (First Floor) on 6/5/14. 2. All sinks used for housekeeping purposes such as mopping will be inspected for anti-siphon devices. 3. Training and Education will be completed on July 1st and 8th on identifying Anti-siphon devices. Environmental Service will monitor all new and repaired sinks used for housekeeping purposed for anti-siphon devices and will install anti-siphon devices in all sinks. 4. All housekeeping sinks used for cleaning purposes will be inspected through the QA safety inspection process on a quarterly basis. 5. Corrected by: Housekeeping & Maintenance will do QA Start 7/1/14 ~~7/7/14~~ 7/8/14 T.C K McCarthy DON 7/10/14	