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 _____	C 06/17/2015

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 and complaint surveys, started on 06/14/15 and completed on 06/17/15, the sample included 5 residents for complete review, 17 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff removed the restraint for 1 of 1 sampled resident (Resident #8) observed with a restraint. Failure to follow the planned schedule and remove the restraint placed the resident at risk for loss in physical functioning. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included intellectual disabilities and dementia. The physician orders identified "Mitt to (R) [right] hand at all times." The current care plan stated, "Focus: I have potential for pressure ulcer development r/t	F 221	**F-0221 Right To Be Free From Physical Restraints** 1. A restraint assessment will be completed on Resident #8 to determine appropriateness. If other intervention is determined to be appropriate the mitt restraint will be discontinued. 2. All resident with physical restraints have the potential to be affected. 3. All residents with physical restraints will have a restraint assessment completed initially and quarterly. The reason for the restraint will be documented in their medical record using the restraint assessment form. 4. QA will be done quarterly per Restraint Policy 5. Completion: July 20th, 2015.	7/20/15 7/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Thompson | TITLE: CEO | (X6) DATE: 07/10/2015

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 221	Continued From page 1 [related to] immobility and friction. . . . I have to wear a mitt on my right hand to prevent me from scratching my peri area and causing it to become raw. It is considered a restraint. I have tried without the mitt and I start scratching right away. . . . Interventions/Tasks . . . I wear a mitt to my right hand at all times except during cares. It prevents me from scratching. . . ." The "Restraint assessment," dated 04/08/15, identified, ". . . Mitt will be removed during cares and resident will be supervised during this time. . . ." Observation on 06/16/15 at 10:10 a.m. showed a certified nursing assistant (CNA) (#13) removed the restraint during the resident's bath. The facility failed to remove the restraint during three observed episodes of personal cares. During an interview on 06/17/15 at 9:30 a.m. a managerial nurse (#2) confirmed staff should release the restraint during cares.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		7/20/15

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F 225	Continued From page 2 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of abuse/neglect investigations, and staff interview, the facility failed to report 2 of 3 alleged incidents (incident on 12/27/14) of abuse/neglect immediately to the State survey and certification agency and failed to thoroughly investigate and report the results of their investigations by the fifth day to the State survey and certification agency. Failure to report and thoroughly investigate all alleged violations has the potential to place all residents at risk of possible abuse/neglect.	F 225	**F-0225 Investigate/Report Allegations/individual** 1. All staff will be re-educated on the protocol to who they should report all alleged violations of mistreatment, abuse, and injury of Unknown Origin. Staff will be educated on the required time frames in which to report the allegation. Training will consist of the abuse reporting form, the time frame in which to report, the requirements that need to be followed once an incident occurs, and documentation of the investigation. Education will occur on 7/13 - 14/2015. 2. All residents have the potential to be affected. 3. Abuse policy and all facility investigation forms will be reviewed and updated as necessary. 4. A quarterly review of all abuse allegations will be conducted by the appropriate department coordinator and Administrator. 5. This will be completed by 7/20/15.	7/20/15

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F 225	Continued From page 3 Findings include: Review of the facility policy titled "Abuse Policy" occurred on 06/17/15. This policy, revised 01/30/15, stated, ". . . Any employee who sees or suspects abuse will report it immediately to the charge nurse . . . The charge nurse will contact the . . . Administrator or designee, they will immediately report to the State Health Department . . . the allegation of abuse. . . . Confirmed cases of abuse from a resident assistant must be reported to the North Dakota Department of Health, Abuse Registry, as required by regulation within 5 working days of the report of the allegation. . . ." The facility's policy failed to reflect the results of all investigations must be reported to the State survey and certification agency within 5 working days of the incident. Review of investigations of alleged abuse and neglect incidents occurred on 06/16/15 with an administrative staff member (#5) and revealed the following: * The "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft Reporting Form" identified an incident occurred on 12/27/14 (Saturday). The form showed the facility notified the State survey and certification agency on 12/29/14 (Monday), two days after the incident. The facility failed to 1) immediately report the alleged violation of verbal and physical abuse to the State survey and certification agency and 2) failed to provide evidence that the alleged violation was thoroughly investigated. * The "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft Reporting Form" identified an incident occurred on 02/14/15 (Saturday). The	F 225		

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F 225	Continued From page 4 form showed the facility notified the State survey and certification agency on 12/20/15 [sic], six days after the incident. An attachment identified the incident actually occurred on 02/13/15 (Friday). The facility failed to 1) correctly identify the date of the allegation and the date the State survey and certification agency was initially notified, 2) immediately report the alleged violation of neglect to the State survey and certification agency, and 3) failed to provide evidence that the alleged violation was thoroughly investigated. During an interview on the afternoon of 06/16/15, an administrative staff member (#5) confirmed the facility failed to report allegations of abuse/neglect to the State Health Department within 24 hours of the incidents occurring. The facility failed to: * Ensure their policy reflected "all" investigations must be reported to the State survey and certification agency within 5 working days of the incident, * Ensure they correctly identified the date of the allegation and/or the date the State survey and certification agency was initially notified, * Immediately report alleged violations of verbal and physical abuse/neglect to the State survey and certification agency, * Provide evidence that the alleged violations were thoroughly investigated.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246		7/20/15

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F 246	Continued From page 5 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to provide services to accommodate the needs for 1 of 2 sampled residents (Resident #20) with glaucoma. Failure to explain the position and type of food served to a resident with impaired vision increased his difficulty while eating. Findings include: Review of the facility policy/procedure titled "Care Plan" occurred on 06/17/15. This policy, dated September 2015, stated, ". . . PURPOSE: Resident will have a plan of care developed by a multi-disciplinary team that will address the resident's individual needs. All interventions addressed on the care plan must be carried out as stated on the care plan. . . ." Review of Resident #20's medical record occurred on June 16-17, 2015. Diagnoses included unspecified visual loss, and glaucoma. An annual Minimum Data Set, dated 04/04/15, identified the resident as cognitively intact, needed set up assistance for eating, and wore glasses. The current care plan stated, "Focus: . . . Order for therapeutic diet. . . . History of gradual weight loss. Poor vision. 01/30/15- Use of adaptive equipment. . . . Interventions/Tasks . . . Offer blue built up plate with meals. Identify food items using clock method. Offer regular utensils. .	F 246	**F-0246 Reasonable Accommodation Of Needs/preferences** 1. Resident #20 will be visited with and explained how the meal will be presented using the clock method. 2. Assessment of residents with physical impairment will be completed by multi-disciplinary team. Appropriate interventions will be put in place to ensure reasonable accommodation of individual needs. 3. A mandatory in-service will be provided to all staff on 7/13-14/2015 on the proper technique (clock method) for identifying food items to visually impaired residents. Dietitian will instruct CRA students on the identification of food items using the clock method and how to assist residents with other impairments that may hinder their dining experience. 4. Q.A. will be done on residents with impairments and will be monitored by the Dietitians quarterly. 5. Completed by 7/20/2015	7/20/15

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F 246	Continued From page 6 . . Offer cardiac diet with mech [mechanical] soft grd [ground] meat. Offer gravy in a bowl. per MD [medical doctor] order. Offer high calorie mashed potatoes at brunch and dinner. . . ." Observation on 06/14/15 at 4:40 p.m., showed staff served Resident #20 his meal in his room. Staff set up the tray without telling the resident what he received or the position of the food on the tray. Food served included turkey, cranberries, mashed potatoes, stuffing, corn, a bun, dessert, and milk. Staff served the food in a blue plate with built up sides and the milk in a covered two handled mug. Observation on 06/15/15 at 10:50 a.m., showed staff served Resident #20 his meal in his room. The staff serving the food poured the carton of milk into a covered mug and set up the tray without telling Resident #20 what he received or the position of the food on the blue plate and on the tray. The resident started eating his soup. When asked, the resident stated he could not see the food on his plate. Observation on 06/16/15 at 4:35 p.m., showed staff served Resident #20 his meal in his room. Staff serving the food poured the milk into a covered mug and set up the tray without explaining what he received or the position of the food on the blue plate and on the tray, as care planned. During an interview with Resident #20 on the afternoon of 06/16/15, the resident identified he can see shapes, but when looking straight at the food he cannot see it. He stated it would be helpful for staff to tell him what food he receives, and the location of the food on the plate and the	F 246		

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F 246	Continued From page 7 tray. During an interview on 06/17/15 at 8:45 a.m., an administrative nurse (#2) confirmed staff are to follow the care plan.	F 246		
F 253 SS=E	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, record review, and staff interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and orderly environment in 1 of 5 resident care units (Special Care Unit [SCU]). Failure to maintain the environment in the SCU may contribute to a diminished quality of life for residents residing on the unit. Findings include: Observation during the initial tour of the facility, on the morning of 06/14/15, identified the following concerns in the SCU: * Room 1204: duct tape surrounding a window air conditioner and rainwater leaking through the duct tape onto the window sill * paint chipped on door jams and radiators throughout the unit * finish worn off the floors in the Sunshine dining room, west dining room, and activity room with multiple scuffs and black/gray areas on the white flooring	F 253	**F-0253 Housekeeping & Maintenance Services** 1. The Special Care Unit will be an immediate focus area for repairs and cleaning which was identified in the survey report. 2. All areas will be setup on a quarterly rotation for painting and environmental repairs as shown by floor diagram. Cleaning of areas and of wheelchairs will be reviewed and monitored quarterly. 3. Cleaning and paint chips will be identified on the facility safety walk-through form and all areas that are identified either by the walk-through or work orders will be addressed. Educate staff on the scheduling of cleaning wheelchairs/walkers/canes and documentation and the reporting of repairs and needed maintenance. Education will occur on 7/13-14/2015 4. Quarterly facility walk-through will be completed by the safety committee and work orders will be completed if areas need attention. 5. Date of completion 7/20/15	7/20/15 7/20/15

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F 253	Continued From page 8 * mop boards missing in room 1304 and 1306 * heat registers throughout the unit showed an accumulation of dust and/or debris Observation in the SCU on 06/15/15 at 12:55 p.m. showed the following: * the protective covering on the lower half of the wall in the hallway outside the west dining room chipped and pulled away from the wall at the corner * the endcap off the metal heat register and lying on the floor in the multipurpose room creating a risk for residents tripping and/or obtaining a laceration from the sharp edges. A tour of the environment occurred on 06/15/15 at 3:30 p.m. with an environmental services manager (#4). During the tour, the staff member (#4) stated staff planned to strip and wax the floors in the activity and dining rooms this quarter. The staff member (#4) also stated he expected staff to fill out a work order to inform him of needed repairs, such as the broken heat register. On the morning of 06/16/15, when asked about environmental quality assurance monitoring for the SCU, the environmental services manager (#4) provided documentation, dated 05/06/15 which identified walls and radiators in the SCU needed painting. - Review of the facility policy titled "Dietary Assistant *** #2" occurred on 06/17/15. This policy, revised 2014, stated, ". . . 11:40 . . . Clear and sanitize tables, counter, microwave . . ." Observation on the morning of 06/14/15 during the initial tour of the Special Care Unit revealed a walker in room 1216, soiled with dirty brown and	F 253		

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F 253	Continued From page 9 gray build-up on its handles. Observation on 06/14/15 during the evening meal in the SCU assisted dining room revealed the following: *A plastic bedside table with food drips and large chunks of debris along the base and food residual on the tabletop. The wall next to the table had long vertical drip marks, and debris visible. *A second bedside table with a metal frame also had a large amount of food residue along the side of the table and on the metal base frame. *The window above the cream colored vent along the walkway next to the assisted dining room had a splatter of dried debris with drip marks. *The windows above the brown colored vent on the opposite side of the room had large smudged areas, hand prints, and food smears. * The walker from room 1216 had dirty brown and gray build-up on its handles. Observation on 06/15/15 at 8:25 a.m. before the breakfast meal revealed a dining room chair with dried crusty debris on the seat, and another dining room chair with dried residue. The sides of the dining room tables had pieces of food and drips dried on them. On 06/15/15 at 9:00 a.m., Resident #11's wheelchair had dried food on the arm rests, and multiple dried brown drips along the wheelchair's frame. On 06/15/15 at 9:35 a.m., observation of Resident #6's chair identified food in the crevices along the wheelchair base, dried food chunks and drips on the foot pedals. A Certified Nurse Aide (CNA) (#12) stated she planned to take that wheelchair to get washed. She stated the unit	F 253		

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F 253	Continued From page 10 used to have a schedule for cleaning wheelchairs but had not seen it, and the wheelchairs sometimes did not get cleaned. On 06/15/15 at 10:23 a.m., observation in the assisted dining room showed the soiled vents and windows, soiled metal framed bedside table and food residue on the wall and windows remained. On 06/15/15 at 10:35 a.m., observation in the independent dining room showed brown discolored areas of build-up on the ceiling next to the large air vent. On 06/16/15 at 2:35 p.m., the CNA (#12) stated nurse aides, housekeeping, and dietary shared the cleaning for the Special Care Unit dining rooms and staff had confusion at times about who was responsible for which part. On 06/17/15 at 11:25 a.m., the unit secretary (#15) stated aides are expected to clean the wheelchairs and walkers on the resident's first bath day of each week. At that time, a staff nurse (#14) stated staff are expected to clean walkers and wheelchairs any time they were visibly soiled. The facility failed to maintain a clean, comfortable and dignified environment for the residents on the Special Care Unit.	F 253		
F 278 SS=D	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	F 278		7/20/15

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F 278	Continued From page 11 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 3 sampled residents (Resident #14) and one close record (Resident #25) coded for nutrition and hydration intervention to manage skin problems. Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs. Findings include:	F 278	**F-0278 Assessment Accuracy/coordination/certified.** 1. Resident #14 Section M of the MDS was modified on 6/30 and accepted. 2. All residents are at risk. 3. Nutrition assessment and Braden scale are done quarterly and PRN. Interdisciplinary team will determine if nutritional needs are needed for prevention of skin breakdown and/or weight management. 4. Q.A. will be completed on all CAA's of the MDS by dietitian and nursing on a Quarterly basis to ensure MDS accuracy. 5 Date of completion. 7/20/15	7/20/15

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F 278	Continued From page 12 The Long-Term Care Facility RAI User's Manual, October 2014, page M-39 stated, "M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment . . . If it is determined that nutritional supplementation, i.e., adding additional protein, calories, or nutrients is warranted the facility should document the nutrition or hydration factors that are influencing skin problems and /or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed'." - Review of the medical record for Resident #14 occurred June 14-17, 2015. A quarterly MDS, dated 05/23/15, and a significant change MDS, dated 04/03/15, identified no pressure ulcers, wounds, or skin problems. Both MDS's identified nutrition or hydration interventions to manage skin problems during the seven day assessment period. The medical record lacked an assessment to indicate a need for nutrition or hydration interventions specific to a skin problem. - Review of the medical record for Resident #25 occurred June 16-17, 2015. A quarterly MDS, dated 04/13/15, and an admission MDS, dated 10/20/14, identified no pressure ulcers, wounds, or skin problems. Both MDS's identified nutrition or hydration interventions to manage skin problems. The medical record lacked an assessment to indicate a need for nutrition or hydration interventions specific to a skin problem.	F 278		

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	355077	A. BUILDING _____ B. WING _____	C 06/17/2015

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F 318	Continued From page 13	F 318		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/05/14. Based on observation, record review, and staff interview, the facility failed to ensure 5 of 10 sampled residents (Resident #1, #4, #5, #7, and #8) received restorative nursing services. Failure to provide restorative therapy (RT) services as recommended did not provide the residents the opportunity to maintain their range of motion (ROM), balance, strength, and mobility. Findings include: During an interview on 06/17/15 at 9:30 a.m., a managerial nurse (#7) reported RT services should be provided a minimum of three times per week, and if for some reason a session is missed, RT staff should "keep trying" to see the resident during the remaining days of the week. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia.	F 318	**F-0318 Increase/prevent Decrease In Range of Motion** 1. Reviewing and assessing the Restorative exercise Program on Resident #1, #4, #5, #7, and #8. The Functional Maintenance Assistants were educated on 7/1315 and 7/14/15, on how to complete documentation to ensure residents are reaching their goals. Education on how to complete monthly Q.A. will be provided. 2. All residents on a restorative program are at risk. 3. We are using an exercise log to track the minutes and explain why they did not receive therapy, Changes in the program can be made with consulting therapy to ensure they are receiving what is needed to maintain their mobility. Education on log was done to improve tracking and follow-up. 4.A monthly Q.A. will be completed by functional maintenance assistants to ensure appropriate documentation. Monthly Q.A. will be reviewed by rehab. nurse and therapy. Program changes will be made at this time. 5. Date of completion will be on 7/20/15.	7/20/15 7/20/15

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F 318	Continued From page 14 The current physician's orders stated, "Functional Maintenance Program per PT [Physical Therapy]/OT [Occupational Therapy] recommendations. The current care plan further stated, ". . . Goal: . . . Increase mobility. . . . Maintain independence. . . . Interventions: . . . Perform AROM [Active Range of Motion] and exercise per PT/OT recommendations. . . ." The 04/23/15 "Restorative Quarterly Screen" identified, ". . . Met with PT/OT. Resident is able to continue with program as written. . . ." Review of the May 2015 through June 2015 RT documentation showed staff failed to consistently provide active and passive range of motion three times per week as directed. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included muscle weakness. The current physician's orders and care plan stated, "Functional Maintenance Program . . . Goal: Res. [resident] will maintain performance in ROM through review date. Interventions/Tasks: Assist with ROM exercises. . . ." The 05/12/15 "Restorative Quarterly Screen" identified ". . . No changes to be made to program. . . ." Review of the March 2015 through May 2015 RT documentation showed staff failed to consistently provide range of motion three times per week as directed. - Review of Resident #5's medical record	F 318		

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F 318	Continued From page 15 occurred on all days of survey. Diagnoses included muscle weakness. The current physician orders and care plan stated, "Functional Maintenance Program . . . Goal: Will maintain performance in ROM through review date. Interventions/Tasks: Assist with AROM exercises. . . ." The 05/07/15 "Restorative Quarterly Screen" identified ". . . No changes to be made at this time. Discussed with therapy and in agreement. . . ." Review of the March 2015 through May 2015 RT documentation showed staff failed to consistently provide range of motion three times per week as directed. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included osteoarthrosis and lower back pain. The current physician's orders stated, "Functional Maintenance Program per PT [Physical Therapy]/OT [Occupational Therapy] recommendations." The current care plan further stated, ". . . Goal: . . . Maintain mobility. . . . Interventions: . . . Perform AROM and exercise per PT [Physical Therapy]/OT [Occupational Therapy] recommendations. . . ." The 05/22/15 "OT Restorative Aide Program" form outlined an individualized exercise program. Review of the May 2015 through June 2015 RT documentation showed staff failed to consistently provide active and passive range of motion three times per week as directed.	F 318		

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F 318	Continued From page 16 - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included scolosis and quadriplegia. The current physician's order included, "Functional Maintenance Program". The current care plan stated, "Focus: I am on maintenance exercise program for passive ROM. . . . Goal: I will maintain current ROM through review date. . . . Interventions/Tasks: CRA's [certified resident assistant] to perform passive ROM exercises. . . ." The 04/08/15 "Restorative Quarterly Screen" identified, ". . . Will continue with current program. Discussed with therapy and in agreement. . . ." The medical record lacked evidence of any RT provided in April and May 2015. Review of the June 2015 RT documentation showed staff failed to consistently provide passive range of motion three times per week. The facility failed to consistently provide restorative therapy services per physician's order/as care planned.	F 318		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding	F 373		7/20/15

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F 373	Continued From page 17 residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control.	F 373	**F-0373 Feeding Asst – Training/Supervision/Resident** 1. Care plan for resident #27 was updated to identify that a PFA can assist. Resident is on the PFA list. 2. All residents needing meal assistance. 3. Nursing to complete the PFA assessment and document in the care plan if assistance is needed by PFA/CRA. Resident will also be added to the PFA list in each unit. This will be completed quarterly and PRN. If there is a change in resident's eating ability dietary will be notified. 4. Q.A. will be completed on a quarterly basis. Monitored by Q.A. committee. 5. Corrected by: 7/20/15	7/20/15

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F 373	Continued From page 18 Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure nursing staff assessed a resident's ability to be fed by a paid feeding assistant (PFA) for 1 of 2 residents (Resident #27) observed being fed by a PFA. Failure to assess residents to ensure a PFA feeds only residents without complicated feeding problems placed residents at risk for choking and aspiration. Findings include: Review of the facility policy/procedure titled "Paid Feeding Assistants" occurred on 06/17/15. This policy, dated January 2015, stated, ". . . Procedure: . . . Feeding assistants will only feed residents who have no complicated feeding problems. . . . Residents who have no complicated feeding problems will have documentation in a nurse progress note upon assessment and in plan of care, for feeding assistants to assist with feeding. . . ." Observation during the dinner meal on 06/16/15	F 373		

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F 373	Continued From page 19 at 4:30 p.m., showed a PFA assisting Resident #27 to eat. Review of Resident #27's medical record occurred on 06/16/15. The record showed facility staff completed a "PFA Assessment" for the resident on 03/30/15. This assessment identified the nurse did not approve a PFA to feed the resident. The current care plan failed to identify Resident #27 is approved to be fed by the PFA. During an interview on the morning of 06/17/15, an administrative nurse (#3) identified the assessment completed in March is accurate as Resident #27 ate independently at that time. The nurse (#3) identified staff need to complete a new assessment when residents have a change in eating ability.	F 373		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the availability of functioning emergency equipment for use for 2 of 3 suction machines (second and third floor). Failure to have functioning suction machines readily available for use placed residents requiring emergency suction at risk for choking and aspiration. Findings include:	F 456		7/20/15

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F 456	Continued From page 20 - Observation with an administrative nurse (#3) of the emergency equipment for the second floor occurred on 06/17/15 at 8:25 a.m. The suction machine lacked a canister, and therefore was not functional or available for timely use. The administrative nurse (#3) identified staff obtain replacement canisters from materials management and should have replaced it once staff used the previous canister. - Review of the third floor suction machine storage occurred on 06/17/15 at 9:37 a.m. with a staff nurse (#1). Observation showed a suction machine in a storage room. The suction machine lacked tubing. The nurse (#1) called a managerial nurse (#2) who verified the tubing was not readily available and obtained it from a supply room. The managerial nurse (#2) confirmed supplies need to be immediately available for the suction machine. Failure to have the essential supplies immediately available could delay the implementation of emergency treatment for a resident requiring suction.	F 456	**F-0456 Essential Equipment, Safe Operating Condition** 1. Suction machines on 2nd and 3rd floor have appropriate supplies available. 2. All suction machines will be checked for appropriate supplies monthly. Supplies for suction machines will be replenished after every use by nursing. 3. Quarterly checks of suction machines will be added to the safety committee walk-through list. 4. Suction machines quarterly report will be reviewed by the Q.A. Committee and monitored by nurses in each area. 5. Corrected by: 7/20/15	7/20/15
F9999	FINAL OBSERVATIONS Based on observation, record review, staff interview, resident interview, and family interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid recertification survey could not be substantiated.	F9999		