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 _____	09/28/2017

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 09/25/17 and completed on 09/28/17, the sample included 5 residents for complete review, 17 residents for focused review, and 3 closed records for review.	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 3 of 14 sampled residents (Resident #17, #18, and #19) in a manner and environment that maintained each resident's dignity. Failure to provide care that enhanced dignity, did not promote Resident #17, #18, and #19's dignity and/or enhance their quality of life. Findings include: - Observation on 09/26/17 at 11:00 a.m. and 09/27/17 at 10:53 a.m. showed Resident #17 sat in his wheelchair next to an independent table in the dining room. Resident #17 had residue covering/dripping from his chin. During both observations, Nursing staff seated at his table and/or serving residents in the dining room failed to provide verbal cues and/or assistance to wipe the residue from his face.	F 241	1. All staff will be re-educated on 10/24 and 10/25/17 on the importance of maintaining dignity during all times. Resident 17, 18 & 19 are all supervised during meals and cues/assistance is given when food/drool is on their face to maintain their dignity. 2. All residents have the potential to be at risk. 3. A mandatory in-service will be held on 10/24/17 and 10/25/17 to educate all staff on the importance of maintaining all residents dignity. 4. 10/26/17 5. Q.A. will be completed by nurse managers and dietitian weekly for one month, monthly for 3 months and then quarterly till resolved. Q.A. will be completed on resident and staff to ensure dignity is maintained in dining room. Q.A. was started 10/9/17.	10/26/17

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

Electronically Signed | 10/20/2017

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 241	Continued From page 1 - Observation on 09/25/17 at 4:50 p.m., 09/26/17 at 4:53 p.m., and 09/27/17 at 5:12 p.m. showed Resident #18 sat in his wheelchair next to an independent table in the dining room. Resident #18 had residue covering/dripping from his chin. During all three observations, Nursing staff seated at his table and/or serving residents in the dining room failed to provide verbal cues and/or assistance to wipe the residue from his face. - Observation on 09/26/17 at 11:00 a.m. showed Resident #19 sat in her wheelchair next to an independent table in the dining room. Resident #19 leaned to her right side, and had drool/residue dripping from her chin. During the observation, Nursing staff serving residents in the dining room failed to provide verbal cues and/or assistance to wipe the residue from her face. During an interview on the afternoon of 09/28/17, a managerial nurse (#2) confirmed staff should cue and/or assist residents with wiping drool and/or residue from their faces.	F 241		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		10/26/17

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F 309	Continued From page 2 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 3 of 8 sampled residents (Resident #4, #17, and #18) diagnosed with dysphagia received the services necessary to ensure their safety during meals. Failure to provide proper positioning, supervision, and/or cueing has the potential to negatively affect Resident #4, #17,	F 309	1. Residents 4, 17 and 18 care plans were updated with interventions on proper care during meal times. Education will be provided to all staff 10/24/17 and 10/25/17 on proper care/interventions of those with dysphagia diet. 2. All residents on dysphagia diet have the potential to be at risk.	

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F 309	Continued From page 3 and #18's overall swallow safety, and placed them at an even greater risk of aspiration. Findings include: Review of the facility policy "Dysphagia" occurred on 09/28/17. The policy, revised 06/14/17, stated, ". . . Signs of potential aspiration include: Coughing . . . while eating or drinking, Wet and/or gurgly sounding vocal quality during meals . . . The following is to be done during meals: Position resident upright, 90 degrees, for meals . . . Allow adequate time and verbal prompts for chewing and swallowing . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, reflux, and moderate dysphagia. The quarterly Minimum Data Set (MDS), dated 08/09/17, identified severely impaired cognition and extensive assistance of one person required during meals. The current care plan also identified, ". . . Monitor positioning of resident. . . ." A bedside dysphagia assessment, dated 02/15/17, identified, ". . . Dysphagia: Moderate . . . Diet: Mechanical soft . . . thin liquids . . . Feeding Procedures: Nursing supervision, Resident in upright position . . . May require feeding assist. . . ." Observation showed the following: * On 09/25/17 at 4:50 p.m., Resident #4 sat at an assisted table in the dining room, with his chair reclined to an approximate 45 degree angle. Resident #4 cleared his throat three times and coughed three times during the meal. The	F 309	3. All residents with a dysphagia diet has had care plans updated with proper intervention for care during meal times. All staff will be educated on interventions and care plans during a mandatory in-service for all staff on 10/24/17 and 10/25/17. 4. 10-26-17 5. Q.A. will be completed by nurse managers and Q.A. nurse weekly for one month, monthly for 3 months and quarterly till resolved. Q.A. will be completed on residents and staff to ensure quality of care is maintained during meals. Q.A. was started 10/9/17.	

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F 309	Continued From page 4	F 309		

certified nursing assistant (CNA) (#3) failed to raise Resident #4's chair to a 90 degree angle prior to feeding him.
* On 09/26/17 at 10:55 a.m., Resident #4 sat at an assisted table in the dining room, with his chair reclined to an approximate 75 degree angle. Resident #4 cleared his throat during the meal. The certified nursing assistant (CNA) (#4) failed to raise Resident #4's chair to a 90 degree angle prior to feeding him.

- Review of Resident #17's medical record occurred on September 27-28, 2017. Diagnoses included Huntington's disease, dementia, and moderate-to-severe dysphagia. The quarterly MDS, dated 09/01/17, identified moderately impaired cognition and set-up assistance required during meals. The current care plan also identified, ". . . I require supervision . . . with eating r/t [related to] dysphagia. . . ."

A bedside dysphagia assessment, dated 04/14/16, identified, ". . . Dysphagia: Moderate-severe . . . Diet: Mechanical soft textures . . . honey thick liquids . . . Feeding Procedures: Nursing supervision . . . Complete double swallow, Observe for pocketing, Alternate liquids & solids . . . Resident may need verbal cues at mealtime. . . ." The 09/01/17 MDS failed to capture the swallowing study recommendations; including the need for supervision during meals.

Observation showed the following:
* On 09/26/17 at 11:00 a.m., Resident #17 sat in his wheelchair next to an independent table in the dining room. Resident #17 had residue covering/dripping from his chin.

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F 309	Continued From page 5 * On 09/27/17 at 10:53 a.m., Resident #17 sat in his wheelchair next to an independent table in the dining room. Resident #17 took two-to-three bites of food and/or sips of liquid at a time, had residue covering/dripping from his chin, and coughed four times during the meal. At one point, an unidentified CNA, sitting at a nearby table, looked at Resident #17 as he coughed, and then turned back towards the resident she was feeding when he stopped coughing. During both observations, Nursing staff failed to provide direct supervision, verbal cues to double swallow and/or alternate liquids and solids, and check for pocketing. - Review of Resident #18's medical record occurred on September 27-28, 2017. Diagnoses included cerebrovascular accident (stroke) with hemiplegia and severe dysphagia. The quarterly MDS, dated 09/09/17, identified severely impaired cognition, set-up assistance, and supervision required during meals. The current care plan also identified, ". . . Staff . . . to supervise resident during meals to monitor swallowing. Encourage resident to slow down with food. . . ." A bedside dysphagia assessment, dated 12/09/16, identified, ". . . Dysphagia: Severe . . . Diet: Puree textures . . . pudding thick liquids . . . Feeding Procedures: Nursing supervision . . . Controlled amounts, Chin down when swallowing . . . Complete double swallow, Observe for pocketing, Alternate liquids & solids . . . Resident may need verbal cues at mealtime. . . ." Observation on 09/26/17 at 4:53 p.m. showed Resident #18 sat in his wheelchair next to an	F 309		

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F 309	Continued From page 6 independent table in the dining room. Resident #18 had residue covering/dripping from his chin, coughed once, and presented with a wet, gurgly vocal quality. Nursing staff failed to provide direct supervision, verbal cues to take small bites of food and/or sips of liquid, tuck his chin when swallowing, double swallow, alternate liquids and solids, and check for pocketing. During an interview on the afternoon of 09/28/17, a managerial nurse (#2) confirmed staff should ensure proper positioning of residents prior to offering them food/liquids and supervise/cue residents as needed.	F 309		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	F 356		10/26/17

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F 356	Continued From page 7 (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post nursing staff information (posting of staff) that included the name of the facility, the actual hours worked per shift by registered nurses (RN), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care on 5 of 5 nursing units (1st floor North, Cottage, Special Care Unit, Second Floor and Third Floor). Failure to post the nurse staffing with all the required information	F 356	1.Nurse direct staff daily report was changed to include: Facility name, current date, total number of staff and actual hours. Separating RN's, and LPN's on staffing sheet, CNA's, CMA's, FMA, CRA helpers and daily census posted in all areas. 2. All residents are at risk of not getting all the staffing information accurately. 3. Nursing staff have been educated on	

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F 356	Continued From page 8 denied residents and visitors the opportunity to be informed of current staffing levels. Findings include: Observation on the morning of 09/28/17, of all five nursing units, showed the posting provided lacked the facility name, identified nurses, did not separately identify RNs and LPNs and clearly identify the hours worked by RNs, LPNs and CNAs. During an interview on 09/28/17 at 11:45 p.m., an administrative nurse (#1) confirmed the current facility posting of staff lacked the above information.	F 356	how to fill out sheet correctly on 10/13/17 as needed. All staff education mandatory in-service will be on 10/24/17 and 10/25/17 on how and why posted nursing staff information is completed correctly. 4. 10/26/17 5. Q.A. will be completed by QA nurse weekly for one month, monthly for 3 months and then quarterly till resolved. Q.A. will be completed on nursing staff putting information correctly on form. Q.A. was started 10/13/17.	