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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 03/10/14 and completed on 03/13/14, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation.	4/28/14
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 2 of 4 sampled residents (Resident #1 and #10) who received personal cares in bed. Failure to cover a resident's exposed body (Resident #1) and failure to pull the privacy curtain during cares (Resident #10) does not promote residents' dignity, self esteem, self worth, or enhance their quality of life. Findings include: - Observation on 03/12/14 at 8:05 a.m., showed the privacy curtain and window drape closed/drawn in Resident #1's room and the resident lying supine in bed with her pajama top on, her naked body exposed from her waist to her feet, and a used incontinent product located at	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaylene Kuetzinger | TITLE: Administrator | (X6) DATE: 4-16-14

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 241	Continued From page 1 the foot end of the bed. A certified nursing assistant (CNA) (#20) stated she needed to leave the resident's room to get a wash cloth. The CNA left the room and failed to cover the resident's exposed body prior to leaving the room. A few minutes later, the CNA (#20) returned to the room and stated she was unable to locate any clean wash clothes and "sometimes this happens" (referring to running out of wash clothes). The CNA provided Resident #1 with a wet wipe (typically used to complete perineal cares) to wash her hands and face. Review of Resident #1's medical record occurred on March 10-13, 2014. Diagnoses included dementia, anxiety, major depression, and stress incontinence. The quarterly Minimum Data Set, dated 02/22/14, identified moderate cognitive impairment, mild depression, one person physical assistance for bed mobility, transfers, dressing, personal hygiene, and toilet use. The current care plan identified "1 staff participation" for the completion of AM/PM Cares of dressing and personal hygiene. - Observation on 03/12/14 at 3:55 p.m. showed two CNAs (#10 and #11) provided perineal cares while Resident #10 laid in bed. The CNAs (#10 and #11) failed to pull the privacy curtain and close the window blinds prior to providing cares. Review of Resident #10's medical record occurred on March 12-13, 2014 and diagnoses included dementia, contracture and stiffness of joint. The quarterly MDS, dated 03/05/14, identified severely impaired cognition, total assistance required for toilet use, and extensive assistance required for personal hygiene. The	F 241	F 241 For resident #1 and #10, we educated direct care staff on 3/25/14 on the importance of providing for resident dignity during cares. Staff are covering resident during cares and privacy curtains are being pulled to protect dignity. All residents could be affected. By educating staff residents will be insured their privacy. Mandatory staff inservice on 4/14/14 and all staff viewed the video "Preserving Residents' Dignity for Staff Members in Long Term Care" on 4/7/14. Systems Change: Additional wash cloths were ordered to insure that there is an adequate supply. An audit tool has been created on providing dignity during cares. The audits will be completed weekly X 4 weeks and monthly x 2 months. The audit will be completed by DNS or designee. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14

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F 241	Continued From page 2 current care plan stated, ". . . The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Dementia e/b [evidenced by] is total dependent . . . PERSONAL HYGIENE: Resident requires total assistance with personal hygiene care. . . ." During an interview on 03/13/14 administrative staff members (#1 and #12) confirmed the CNAs should have pulled the resident's privacy curtain and closed the window blinds.	F 241		
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 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.	F 278		

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 11 sampled residents (Resident #5) coded inaccurately for Activities of Daily Living (ADLs). Failure to accurately assess and code Resident #5's MDS regarding toilet use, personal hygiene, and walking in his room does not reflect the resident's current status and may affect the level of care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages G-4 and G-6 stated, "In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the type . . . and level of assistance . . . provided by all disciplines. . . ." Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 01/21/14, Section G: Functional Status, identified the following status for the resident during the seven day assessment period: *G0110C: Walk in Room - Supervision and assistance of 1 person (coded 1-2 on the MDS).	F 278	F 278 For resident 5 the MDS dated 1-21-2014 was correctly coded in sections G0110C, G0110I, G0110J . The corrected MDS was completed, submitted to the state, and accepted on 4-9-2014. Care plan was updated in walking, toileting, and personal hygiene. All residents have the potential to be affected in this area. All residents current MDSs reviewed for accuracy. T.C. - adm 4/21/14 dl By educating our staff and with the increased awareness in the accuracy of coding the MDS sections G 0110 C, I, and J we will prevent this from happening to other residents. The MDS Coordinator has received receive education on accurately coding section "G" ADLs of the MDS on 4-9-2014. Systems Change: ADL coding tool given to all nursing staff and placed at all charting kiosks. We will complete 2-3 random chart audits on sections G0110C, G0110I, G0110J of the MDS weekly x 4 weeks, then monthly x 2 months. The audit will monitor if the supportive documentation coded by the CNA's in the point of care documentation match the MDS coding by the MDS coordinator in the areas of resident walking, toileting, and personal hygiene. Audits will be completed by DNS or designee. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14

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F 278	Continued From page 4 *G0110I: Toilet Use - Extensive assistance of 1 person (coded 3-2 on the MDS) *G0110J: Personal Hygiene - Extensive assistance of 1 person (coded 3-2 on the MDS Review of the staff documentation during the seven day assessment period (January 14-21, 2014) failed to show Resident #5 required extensive assistance for toilet use and personal hygiene. An interview occurred on 03/12/14 at 10:05 a.m. with a CNA (#15) and on 03/12/14 at 1:05 p.m. with a CNA (#4). Both CNAs identified Resident #5 as independent in his room except for some set up help. During an interview on the morning of 03/13/14, an administrative nurse (#17) agreed Resident #5's MDS was coded inaccurately.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 5 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 7 of 11 sampled residents (Residents #3, #4, #5, #6, #7, #8, and #10) and 1 closed record resident (Resident #13). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Care Plan And Care Conferences" occurred on 03/13/14. This policy, dated September 2013, stated, ". . . Purpose, To develop a holistic and resident-specific care plan for each individual, upon completion of the assessment, that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial needs. To provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning . . . Procedure . . . 5. Formulating The Care Plan . . . d. Interventions are what staff do to help residents reach their goals and should be: 1. Individualized, realistic and must be written in understandable language for caregiver. 2.	F 280	F 280 For resident #4 the Mobilization support data collection tool was completed and the care plan was updated on 4/1/14 to correct his transfer assistance needed due to the pelvic fracture. For resident 7 the care plan was updated on 4/9/14 to accurately address the current nutritional needs. For resident 10 the care plan as updated to address epilepsy on 4/9/14. For resident 5 the Mobilization support data collection tool was completed and the care plan was updated to address toileting and transfers assistance by staff on 4/9/14. For resident 6 the Mobilization support data collection tool was completed and the care plan was updated to address the current level of assistance needed by staff for transfers on 4-9-2014. For resident 8 the Mobilization support data collection tool was completed and the care plan was updated to address the current level of assistance needed by staff for transfers on 4-9-2014. For resident 3 the care plan was updated to add the use of a personal alarm to address fall interventions on 4/9/14. Resident 13 was discharged on 12/9/13. All residents have potential to be affected in this area. By educating our staff on MDS coding and accurately	4/28/14

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F 280	Continued From page 6 Specific and concise by saying what we plan to do, when we plan to do it and the frequency it will occur. . . . f. The interdisciplinary team will ensure that the care plan is comprehensive by incorporating the following: Physicians' orders and diagnoses that are currently being treated. . . ." - Review of Resident #4's medical record occurred on March 11-12, 2014 and diagnoses included closed fracture of pelvis and generalized pain. A significant change Minimum Data Set (MDS), dated 02/26/14, identified the resident required extensive assistance of two or more persons with transfers and walking in the room or corridor did not occur. The resident's care plan, dated 01/16/14, stated, ". . . The resident is at risk for falls R/t [related to] history of falls . . . Interventions . . . Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function . . . TRANSFER: Resident requires weight bearing support total lift and assist of two . . ." Observation on March 11-12, 2014 showed facility staff utilized a full body lift for transfers. Facility staff failed to update the care plan to indicate Resident #4 no longer ambulates or stands. - Review of Resident #7's medical record occurred on March 11-12, 2014 and diagnoses included Parkinson's disease. The resident's care plan, dated 03/04/14, stated, ". . . The resident has potential nutritional problem R/T does not like pureed diet . . ." Review of a nurse's progress	F 280	care plans addressing residents care needs in the areas of dietary interventions, transfer assistance, toileting needs, and non-pharmacological interventions we will be able to prevent other residents from being affected in this area. Mandatory care plan training was provided on 4-9-2014 for the MDS coordinator and on 4-22-2014 for the dietary manager on how to accurately care plan with a focus on nutritional/dietary interventions, transfer assistance, toileting needs, and non-pharmacological interventions. An audit tool will be created to monitor the accuracy of care plans in the areas dietary interventions, transfer assistance, toileting needs, and non-pharmacological interventions. The audit will be completed on three random residents per week, weekly x 4 and monthly x 2 months. The audit will be completed by LSW or designee. Audit reports will be reviewed at QA to determine if further auditing and/or education is needed.	

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note dated 03/04/14 at 3:30 p.m. stated, "orders received and observed . . . to change diet to regular diet soft, dietary aware of new orders." The facility staff failed to update the care plan to indicate Resident #7's current diet.

- Review of Resident #10's medical record occurred on March 11-12, 2014 and diagnoses included epilepsy. The current care plan failed to address Resident #10's epilepsy diagnosis.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included glaucoma and history of a cerebral vascular accident (CVA) or stroke. The quarterly MDS, dated 01/21/14, identified the resident supervised for locomotion on and off the unit and transferred with limited assistance of one staff member. The current care plan stated, "Focus: The resident has limited physical mobility R/T Stroke e/b has left sided weakness and arthritis . . . Interventions: Ambulation: Resident requires weight bearing support to ambulate in his room with assist of one and gait belt . . ."

During an interview on 03/12/14 at 10:05 a.m., a certified nurse aide (CNA) (#15) stated the staff members lay out Resident #5's clothes in the morning and assist him with his hearing aids and teeth. Resident #5 does everything else himself, including walking into the bathroom independently.

During an interview on 03/12/14 at 1:05 p.m., a CNA (#4) stated Resident #5 is independent except he may need assistance to and from the dining room via wheelchair on occasion.

The care plan failed to reflect Resident #5's

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F 280	Continued From page 8 current status related to mobility/transfers. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The annual MDS, dated 01/24/14, identified the resident required extensive assistance of two or more staff members for transfers and toilet use. The current care plan stated, "Focus: The resident has an ADL [Activity of Daily Living] self care performance deficit R/T Dementia e/b needs assist of one to two with adl's . . . Interventions: Transfer: Resident requires assist of one to two staff participation with transfers." Observation on 03/11/14 at 9:50 a.m. and 10:45 a.m., and on 03/12/14 at 9:55 a.m., showed facility staff utilized a sit-to-stand lift to transfer Resident #6. On 03/11/14 at 5:20 p.m., observation showed facility staff utilized a gait belt for transfer. The care plan failed to clearly identify how facility staff should transfer Resident #6. - Review of Resident #8's medical record occurred on March 12-13, 2014. Diagnoses included dementia and legal blindness. The quarterly MDS, dated 02/22/14, identified the resident required extensive assistance of two or more staff members for transfers. The current care plan stated, "Focus: The resident has an ADL self care performance deficit R/T macular degeneration e/b severe vision loss . . . Interventions: . . . Toilet use: Resident requires 1 to 2 staff participation to use toilet. Transfer: Resident requires 1 to 2 staff participation with transfers."	F 280		

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Observation on 03/12/14 at 5:15 p.m. showed two CNAs (#10 and #11) utilized a gait belt and pulled up on Resident #8's pants and transferred her from bed to a wheelchair. Observation showed the resident's knees bent and unable to stand in a full upright position

Observation on 03/13/14 at 9:50 a.m., showed a CNA (#4) applied a gait belt around Resident #8's waist, faced her, and lifted her up with the gait belt from the wheelchair while another CNA (#14) moved the wheelchair and replaced it with a commode. Observation showed Resident #8's knees bent and leaned backward as the CNA (#4) held her up.

Observations during the survey showed Resident #8 unable to bear weight and required two staff members to provide transfer assistance even though the care plan identified one or two staff members required. The facility failed to revise the care plan to clearly indicate and identify the need of two staff members to safely provide transfer assistance to Resident #8.

- Review of Resident #3's medical record occurred on March 11-13, 2014. Diagnoses included paralysis agitans (a form of muscle rigidity not caused by paralysis), and dementia. A quarterly MDS, dated 02/25/14, identified the resident experienced long and short term memory problems, required extensive assistance of two or more staff members for transfers, did not ambulate during the assessment period, required extensive assistance of one staff for mobility on and off the unit and experienced falls since the last MDS, one of which resulted in no injury and one with injury. The current care plan stated "Focus: The resident is at risk for falls R/T

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F 280	Continued From page 10 Unaware of safety needs e/b history of falls. . . . Interventions: Review and modify environmental hazards that could cause or contribute to fall." The fall care plan included only this one intervention. Observations throughout the survey showed staff utilized a personal alarm for Resident #3 while in his wheelchair. Fall documentation showed the resident's previous falls happened from his wheelchair. The care plan failed to include the resident falls from his wheelchair and the use of the personal alarm while in his wheelchair. - Review of Resident #13's medical record occurred on March 13, 2014. Diagnoses included paranoid state, depression, and anxiety state. A quarterly MDS, dated 12/06/13, identified the resident with moderately impaired cognition, experienced other behavior symptoms four to six days out of seven, and received antipsychotic, antianxiety, and antidepressant medications daily during the assessment period. The care plan lacked information regarding Resident #13's behaviors and non-pharmacological interventions to attempt prior to dispensing an as needed medication for behaviors.	F 280		
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:	F 281		

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F 281	Continued From page 11 Based on record review and staff interview, the facility failed to ensure adequate medication availability for 1 of 1 sampled resident (Resident #9). Failure to provide medication for the treatment of paralysis agitans for Resident #9 had the potential to increase his muscle stiffness/tremors and may have resulted in increased pain and discomfort. Finding include: - Review of Resident #9's medical record occurred March 10-13, 2014. Diagnoses included paralysis agitans and chronic pain. The physician's orders, included ropinirole HCl [hydrochloride], 0.25 milligrams (mg) orally three times daily for the treatment of paralysis agitans. The medication administration record (MAR) for February 2014 showed the following missed doses of ropinirole HCL: 02/15/14 at 8:00 p.m. 02/16/14 at 1:00 p.m. 02/17/14 at 8:00 a.m., 1:00 p.m. and 8:00 p.m. 02/18/14 at 8:00 a.m. and 1:00 p.m. 02/19-21/14 all three daily doses. 02/22/14 at 8:00 a.m. and 1:00 p.m. Nursing documentation related to missed ropinirole HCL doses stated: 02/15/14 at 7:41 p.m., ". . . med [medication] unavailable/ not given." 02/16/14 at 1:04 p.m., "Medication not available to be administered. Resident receives his supply of meds from [supplier's name]." 02/17/14 at 8:21 a.m. and 12:21 p.m., ". . . med has been ordered." 02/17/10 at 7:01 p.m., "Medication not available at this time."	F 281	F 281 For resident 9 the medication supply was received and he has been receiving the medication as ordered since 3-25-2014. Any resident who receives medication through a mail order pharmacy has potential to be affected in this area. The DNS has reviewed all of the residents' medications that are received through mail order pharmacy to ensure that they receive medication without interruption and a system in place for monitor the supply of all mail order medications so that when the medication arrives it is reordered immediately. System Change: Procedure developed to obtain a supply of medication from the local pharmacy if mail order medications do not arrive in a timely manner. On 3-25-2014 a mandatory nursing meeting to educate staff on the new medication procedure that will ensure residents do not have an interruption in scheduled medications start on 4/14/14. An audit tool will be created to monitor the supply of mail order medications. The DNS or designee will be responsible for the completion of the audits. The audit will be completed weekly x 4 weeks and monthly x 2 months to assess if mail order medications were given as ordered. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14

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F 281	Continued From page 12 02/18/14 at 8:12 a.m., ". . . on order from pharmacy." 02/19/14 at 8:12 a.m. and 12:15 p.m., ". . . Med has been ordered." 02/19/14 at 7:11 p.m., ". . . drug not available. ordered." 02/20/14 at 8:22 a.m., ". . . on order from pharmacy." 02/20/14 at 12:39 p.m. "medication has not been delivered yet. Ordered from [supplier's name]." 02/20/14 at 8:37 p.m. ". . . med not given/unavailable." 02/21/14 at 8:31 a.m. ". . . on order from [supplier's name]." 02/21/14 at 12:48 a.m. "Med has not been delivered from [supplier type] pharmacy yet." 02/22/14 at 8:17 p.m., ". . . Med has been ordered." 02/22/14 at 11:06 a.m., "call placed to son [son's name] made aware that resident has been out of ropinrole [sic] for a few days and that [supplier's name] won't send out new script until feb. [sic] 28th, son [son's name] said to go ahead and order from [store name] a 30 day supply for about $22 call placed and [store staff member's name] at [store name] and made aware." 02/22/14 at 12:13 p.m., ". . . Med has been ordered." During an interview, on the morning of 03/13/14, an administrative nursing staff member (#1), when asked, this staff member did not explain the delay in obtaining medication for Resident #9. The facility first documented Resident #9's supply of ropinirole as unavailable for the 8:00 p.m. dose on 02/15/14. The facility failed to arrange for a temporary supply of medication until seven days later. This delay caused Resident #9 to miss 21	F 281		

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F 281 F 309 SS=E	Continued From page 13 doses of ropinirole HCL. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia for 3 of 3 sampled residents (Resident #3, #8, and #9) and 1 of 1 supplemental closed record (Resident #13) with a diagnosis of dementia and who received as needed (PRN) medications for behaviors. Failure to identify the reason for administering the medication and attempt non-pharmacological interventions prior to administering medications, evaluate the effectiveness of the interventions, and establish accurate on-going monitoring of the behaviors has the potential to prevent these residents from achieving their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "PSYCHOPHARMACOLOGICAL MEDICATIONS AND SEDATIVE/HYPNOTICS" occurred on 03/13/14. This policy, revised September 2013,	F 281 F 309	F 309 For resident 3 ,8 & 9 the care plan intervention on having staff attempt and document non pharmacological interventions has been updated to require staff to document Q shift on the attempt to use non-pharmacological interventions for residents on PRN antianxiety or antipsychotic medications. Resident #13 was discharged on 12/9/13. Systems change: Nurses have been given a prn antianxiety tool placed on medication carts and in nurses' station on 3/14/14. (See attachment) All residents who have orders for prn antipsychotic and antianxiety medications could have the potential to be affected in this area. Four residents have been identified that need to have the care plans updated to require staff to document the attempts of non-pharmacological interventions prior to administering PRN antipsychotic and antianxiety medications. A nursing meeting will be held on 3-25-2014 to educate nursing staff on the procedure titled Psycho-pharmacological medications and sedative hypnotics with a focus on the need for staff to document their attempts at using non-pharmacological interventions prior to the	4/28/14

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F 309	Continued From page 14 stated, PURPOSE: To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics . . . PROCEDURE: Non-Emergency Administration 1. Prior to administration of non-emergency psychopharmacological . . . the following must be completed: a. Documentation in the Hands On application or in the medical record observations of mood symptoms or behaviors that cause the resident distress and/or endangers the resident or others and response to interventions used . . ." - Review of Resident #8's medical record occurred on March 12-13, 2014. Diagnoses included senile dementia with delusional features. Medications included Klonopin (an anticonvulsant also used for behaviors) 0.5 milligrams (mg) daily and 0.5 mg twice daily as needed, Seroquel (an antipsychotic) 25 mg daily, and Zoloft (an antidepressant) 100 mg daily. Review of Resident #8's care plan stated, "Focus: The resident has a behavior symptom R/T [related to] dementia E/B [evidenced by] calls out, accuses others of taking advantage of her. She recieves [sic] an anxiolitic and antipsychotic . . . Interventions: *Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. *Provide opportunity for positive interaction, attention. Stop and talk with him/her as passing. *NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions: Allow her to stay in her room. Sit with her 1:1 [one to one] in a quiet setting when she is upset. Remove from busy areas if she is upset."	F 309	licensed nurse administering a PRN antianxiety or antipsychotic medication. An audit tool will be created to monitor the documented evidence of staff using non pharmacological interventions prior to the licensed nurse administering a PRN antianxiety or antipsychotic medication. The DNS or designee will be responsible for the completion of the audit weekly x 4 weeks and monthly x 2 months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	

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Review of the PRN Medication Administration Record (MAR) from December 2013 to February 2014 identified Resident #8 received PRN Klonopin for anxiety on seven occasions.

The medical record lacked evidence the facility staff attempted non-pharmacological interventions prior to the administration of the Klonopin and failed to identify/document the actual behavior exhibited by Resident #8 that resulted in the administation of the medication.

- Review of Resident #3's medical record occurred on March 11-13, 2014. Diagnoses included paralysis agitans (a form of muscle rigidity not caused by paralysis), chronic pain, depression, dementia, and generalized anxiety disorder. Medications included Ativan (an antianxiety medication) 1 mg every four hours as needed for restlessness and agitation related to generalized anxiety disorder, Seroquel (an antipsychotic) 12.5 mg in the morning and 25 mg at bedtime prescribed for depression, trazodone hydrochloride (an antidepressant) 100 mg at bedtime, and Zoloft (an antidepressant) 100 mg in the morning.

The current care plan for Resident #3 stated, "Focus: The resident has a behavior symptom R/T Dementia E/B resists cares at times, has been physically aggressive at times. Receives an antipsychotic. . . . Interventions: * Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. * Provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. * Minimize potential for resident's disruptive behaviors by

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offering tasks which divert attention such as give him items to fidget with. *
NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions: Separate him from others if he is aggressive. Give him items to fidget with, such as the tool box [sic] with large bolts and washers. Give him the metal puzzle to fidget with. . . . Focus: The resident uses psychopharmacological medication R/T depression E/B history of physical and verbal aggression. . . . Intervention: . . .
*MOOD/BEHAVIOR: Attempt non-medication approaches: Reapproach later. Have another staff member try. Give him items to fidget with. Has a stuffed dog. Attempt to give him that."

Review PRN MAR, from January 25, 2014 to March 13, 2014 identified Resident #3 received PRN Ativan on eight occasions.

The medical record lacked evidence the facility staff attempted non-pharmacological interventions prior to the administration of the Ativan and failed to identify/document the actual behavior exhibited by Resident #3 that resulted in the administration of the medication.

- Review of Resident #9's medical record occurred March 12-13, 2014. Diagnoses included chronic pain, dementia, hallucinations, generalized anxiety disorder, and depression. Medications included lorazepam (Ativan) 0.5 mg orally up to three times a day for hallucinations, sertraline (an antidepressant) 25 mg orally daily, and Tylenol 500 mg two tablets twice a day for breakthrough pain.

The current care plan for Resident #9 stated, "Focus: The resident has a mood problem R/T

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depression, dementia and multiple medical conditions E/B chronic fatigue, falls asleep even when in the middle of meals, activities and visiting, trouble concentrating, gets upset with staff easily. Receives an anxiolytic and an antidepressant. . . . Interventions: * Provide resident with a program of activities that is meaningful and of interest . . . * Provide encouragement/assistance/support to maintain as much independence and control as possible. * NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions: Check that oxygen canulas are in place. Check that oxygen is running. Validate fillings. Remove from area if able. Close curtain to reduce glare. Turn on soft music. Offer distracting activities: i.e. crafts, sorting items, folding items. . . . Focus: The resident is resistive to care R/T dementia E/B refuses to lay down at times. . . . Intervention: . . . * If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. * Negotiate a time for ADLs so that the resident participates in the decision process. If she wants to get up at night. Get her up and tell her you will be back in 30 to 60 minutes to help her back into bed. * Educate resident/family of the possible outcome(s) of not complying with treatment or care."

Review of the PRN MAR from January to March 2014 identified Resident #9 received Ativan on 11 occasions. On four of these occasions staff also administered Tylenol.

The medical record lacked evidence facility staff attempted non-pharmacological interventions prior to the administration of the Ativan and failed to identify/document the actual behavior exhibited by Resident #9 that resulted in the administration

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F 309	Continued From page 18 of the Ativan. Failure to attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering an anti-anxiety medication does not allow staff the ability to evaluate what interventions assist Resident #9 to deal with her anxiety and resultant behavior. Staff administering Ativan with Tylenol does not allow the facility to determine which medication provided relief for Resident #9. - Review of Resident #13's closed medical record occurred on March 13, 2014. Diagnoses included paranoid state, dementia, anxiety state, and depression. Medications included Ativan 0.5 mg orally twice daily and Ativan 1 mg orally every four hours as needed for paranoid state, Risperdal (an antipsychotic) 0.25 mg twice a day, and Celexa (an antidepressant) 20 mg daily. The current care plan for Resident #13 lacked non-pharmacological interventions staff should attempt prior to administration of PRN Ativan. Review of the PRN MAR from October to November 2013 identified Resident #13 received PRN Ativan for anxiety on 11 occasions. The medical record lacked evidence facility staff attempted non-pharmacological interventions prior to the administration of the Ativan and failed to identify/document the actual behavior exhibited by Resident #13. Failure to attempt an appropriate non-pharmacological intervention related to Resident #8's, #3's, #9's, and #13's behavior and monitor the effectiveness of that intervention prior	F 309		

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F 309	Continued From page 19 to administering an as needed antianxiety medication does not allow staff to evaluate what interventions are most effective for the behavior and may miss an opportunity to decrease the resident's antipsychotic medication. Failure to document a reason (identify a specific behavior) for administering an as needed antianxiety medication does not allow staff the ability to evaluate the effectiveness of the medication related to those behaviors.	F 309		
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: 1. Based on record review and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #8) received the care and services necessary to attain the highest degree of safety possible while drinking hot coffee. Failure to provide coffee at a safe temperature resulted in Resident #8 sustaining burns on her body and caused unnecessary discomfort and pain. Failure of the facility to implement a system to monitor the temperature of the coffee dispensing machines used by residents has the potential to result in additional burns to residents who drink coffee.	F 323		

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F 323	Continued From page 20 Findings include: Review of Resident #8's medical record occurred on March 12-13, 2014. Medical diagnoses included dementia. The current Minimum Data Set (MDS), dated 02/22/14, identified both long and short term memory problems and severe impairment in making daily decisions. Review of Resident #8's "Incident Details" report, dated 07/29/13 at 6:00 p.m., stated, " . . . Comment: Resident spilled hot coffee on . . . herself resulting in a burn, red area with some blistering . . . Immediate Interventions: Closer monitoring needed in dining room." Review of Resident #8's progress notes stated the following: *07/29/13 at 7:00 p.m. - "Resident sustained burn 10 cm [centimeters] X [by] 7 cm after spilling hot coffee on self . . ." A physician's order, dated 07/29/13, stated, "Apply ice PRN [as needed] to affected area. Vicodin [a pain medication] [every four hours] for pain. Bacitracian to affected area." *07/30/13 at 1:00 p.m. - ". . . Blisters to [right] thigh intact . . ." *08/16/13 at 2:00 p.m. - "Noted to [right] upper thigh where coffee spill was noted to have foul odor green drainage. Call to [provider's name] orders received/observed for silvadene (top) [topical] . . . to [right upper] thigh til [sic] healed. Keflex [antibiotic] . . . 10 days . . ." *10/07/13 - ". . . burn area is scarred." Observation on 03/13/14 at 8:55 a.m. showed Resident #8 seated in the dining room in a reclined wheelchair about two feet from the table. An unidentified Certified Nursing Assistant (CNA)	F 323	F 323 Part 1: For resident 8 the care plan was updated to have all hot beverages served in a covered cup. Part 1 For residents 6, 7, and 8 a mobilization support data collection tool was completed to determine proper method of transfer and care plan updated to address transfer needs. Staff will be educated on the transfer plan for all three residents. Part 2: All residents that consume hot beverages have the potential to be affected in this area. By educating our staff and with the increased awareness in beverage temperatures we will prevent this from happening to other residents. Part 2: All residents that require extensive assistance with transfers has the potential to be affected in this area. By correctly assessing our residents and provided training to staff on safe resident transfers with mechanical lifts and transfer belts will prevent other residents from being affected in this area. Staff development coordinator will review each residents care plan for accuracy of resident transfer needs. Systems change: Hot Coffee: The temperature of the coffee machine has been turned down.	4/28/14

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F 323	Continued From page 21 handed the resident a cup of coffee with a lid and stated she, "added a little cold water cuz [because] it was hot." Observation showed Resident #8 drank the coffee independently. At 9:05 a.m., the survey team obtained a cup of coffee from the coffee dispenser, immediately checked the temperature, and found the temperature measured 165.4 degrees Fahrenheit. During an interview on the morning of 03/13/14, two administrative staff members (#1 and #2) stated they did not conduct an investigation related to Resident #8's coffee burn and they do not know what the coffee temperature was on the day of the incident. The staff member (#2) stated the dietary department periodically checked the temperature of the coffee. The staff member could not provide documentation of any completed temperature monitoring reading from the coffee dispensing machine. The staff member (#1) stated the incident happened around the time staff members were assisting/transferring residents into the dining room and Resident #8 should not have been alone with a cup of hot coffee. The staff members (#1 and #2) did not know whether Resident #8's coffee cup had a lid on it during the time of the incident. Failure to implement a systemic process to monitor and check the temperature of the coffee dispensing machine continues to place Resident #8 and all residents of the facility at risk of sustaining burns due to excessively hot coffee temperatures. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the proper use of assistive devices for	F 323	Dietary staff will check temperatures of hot beverages randomly throughout the week to be sure it is a suitable temperature before being served to our residents. All staff training on 4-14-2014 on the procedure titled "Hot Beverages" and what temp hot beverages are safe to be served to residents. And to educate staff the procedure titled "Burns" and how staff need to properly respond to a burn injury. Nursing Education has been provided on the procedure titled "Mechanical Lift" and the need to have the front safety strap on the resident below the sternum level. All nursing staff were trained in transfer/lift competency to assure awareness of proper transfer for each resident and proper use of all mechanical lifts, harnesses, and straps. Random daily audits on monitoring the temperature of coffee will be completed by Dietary Manager or designee weekly x 4 weeks then monthly x 2 months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training. An audit will be developed to monitor transfers including the accuracy of the assessment, if the care plan is correct, and if staff performed the transfer correctly	

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F 323	Continued From page 22 2 of 7 sampled residents (Resident #6 and #8) observed during gait belt transfers and 1 of 2 sampled residents (Resident #6) observed during a sit-to-stand lift transfer; and failed to lock the wheelchair brakes for 1 of 8 sampled residents (Resident #7) observed during a transfer into a wheelchair. Failure to ensure staff use gait belts and a sit-to-stand lift appropriately and lock the brakes of a wheelchair during a transfer placed Resident #6, #7, and #8 at risk for falls and injuries. Findings include: Review of the facility policy titled "GAIT (TRANSFER) BELT" occurred on 03/13/14. This policy, dated October 2013, stated: "PURPOSE: *To safely transfer or ambulate resident *To aid resident in maintaining balance *To avoid injury to both resident and staff member . . . PROCEDURE: 1. Show the resident the gait (transfer) belt and explain that it is a device used for stability and/or support for a short time during the actual transfer or ambulation. . . . 5 . . . The belt should not be used for lifting. It is for support and stability only. . . . 7. Do not use the pants/slacks belt as a gait (transfer) belt. . . ." Review of the facility policy titled "MECHANICAL LIFT" occurred on 03/13/14. This policy, dated September 2012, stated, "REFER TO MANUFACTURER'S SPECIFIC LIFT INSTRUCTIONS." The manufacturer's instructions for the Steady-Aid (sit-to-stand lift) stated, ". . . The front safety strap should be	F 323	with the transfer belt, mechanical lift, and safety harness. The SDC or designee will be responsible to complete the audit weekly x 4 weeks then monthly x 2 months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	

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below the sternum level. Tighten the safety strap by pulling on the free end so that the harness is adjusted to a point where it fits snugly around the chest. . . ."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 01/24/14, identified the resident required extensive assistance of two staff members for transfers and toilet use. Resident #6's current care plan related to Activities of Daily Living (ADL) stated, "TRANSFER: Resident requires assist [assistance] of one to two staff participation with transfers."

Observation on 03/11/14 at 9:50 a.m. showed a Certified Nursing Assistant (CNA) (#13) transported Resident #6 into the tub room to use the toilet. Another CNA (#4) entered the tub room with a sit-to-stand lift. The CNA (#13) applied the lift harness around the resident's upper chest area and tightened the safety strap. Observation showed the harness slid up to the Resident #6's neck, just below her chin, and her arms bowed outward during the transfer.

Observation on 03/11/13 at 10:45 a.m. showed two CNAs (#13 and #15) utilized the sit-to-stand lift and positioned Resident #6 over the toilet. The harness had slid up to the resident's neck and her arms were bowed outward. When asked about the position of the harness, the CNA (#15) stated they always place the harness around Resident #6's upper chest to prevent her breasts from getting caught in the harness.

Observation on 03/11/13 at 5:20 p.m. showed Resident #6 seated in a recliner in the activity

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room. The CNA (#6) applied a gait belt around the resident's waist and the CNAs (#6 and #7) both held onto the gait belt with one hand and lifted under the resident's arms with their other hand and transferred Resident #6 into her wheelchair.

Observation on 03/12/14 at 9:55 a.m. showed two CNAs (#15 and #16) utilized the sit-to-stand lift and transferred Resident #6 from her wheelchair to the toilet. During the transfer, the harness slid up to the resident's neck, just below her chin, and her arms bowed outward. The resident stated, "I'm going to fall."

- Review of Resident #8's medical record occurred on March 12-13, 2014. Diagnoses included dementia. The current MDS, dated 02/22/14, identified the resident required extensive assistance of two staff members for transfers and toilet use. The current care plan related to ADLs stated, "TRANSFER: Resident requires 1 to 2 staff participation with transfers."

Observation on 03/12/14 at 5:15 p.m. showed two CNAs (#10 and #11) transferred Residdnt #8 from her bed to a wheelchair. The CNA (#11) applied a gait belt around Resident #8's waist and lifted the resident under her arm with one hand and utilized the gait belt with the other hand. The other CNA (#10) lifted the resident under her other arm with one hand and pulled up her pants with her other hand.

Observation on 03/13/14 at 9:50 a.m. showed showed two CNAs (#4 and #14) transported Resident #8 to her room via wheelchair. The CNA (#4) applied a gait belt around Resident #8's waist, asked the resident to give her a hug, and

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facing the resident, lifted her to a squatting position with the gait belt. While the CNA (#4) held onto Resident #8, the other CNA (#14) exchanged the wheelchair for a commode, pulled down her pants, and the CNA (#4) lowed the resident onto the commode. When Resident #8 had finished on the commode, the CNA (#4) lifted her as before and the CNA (#14) provided pericares.The resident became weak and The CNA (#4) lowered her to the commode for a moment. She then lifted her again and the CNA (#14) pulled up her pants and exchanged the commode with the wheelchair. The CNA (#4) lowered Resident #8 to her wheelchair. Observation showed Resident #8 unable to stand to a full upright position and unsteady on her feet.

- Review of Resident #7's medical record occurred on March 11-12, 2014 and diagnoses included Parkinson's disease. The quarterly Minimum Data Set (MDS), dated 02/22/14, identified the resident required extensive assistance of two or more persons with transfers. The resident's care plan stated, ". . . at risk for falls R/T [related to] Unaware of safety needs e/b [evidenced by] history of falls . . . TRANSFER: Resident requires 1 to 2 staff participation with transfers. . . ."

Observation on 03/11/14 at 9:31 a.m. showed a CNA (#3) applied a gait belt around Resident #7's waist and she and another CNA (#4) transferred the resident from his wheelchair to his bed. Observation showed the CNAs failed to lock the wheelchair brakes prior to the transfer.

Observation on 03/11/14 at 12:56 p.m. showed a CNA (#3) applied a gait belt around Resident #7's waist and she and another CNA (#5) transferred

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F 323	Continued From page 26 the resident from his wheelchair to his bed. Observation showed the CNAs failed to lock the wheelchair brakes prior to the transfer. During an interview on the morning of 03/13/14, an administrative staff member (#1) stated the CNAs can decide what method of transfer to use for each resident and they have the liberty to use more assistance or a lift if necessary, however, if the resident already requires a lift for transfers, the CNAs cannot step down and and use a gait belt or pivot transfer. Failure to evaluate the transfer needs of Resident #6 and #8 resulted in unlicensed staff members (CNAs) determining the level of assistance the residents required. This failure places residents at risk for avoidable falls and injury.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 325		

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F 325	Continued From page 27 to implement dietary interventions to maintain adequate nutritional status and prevent weight loss for 2 of 5 sampled residents (Resident #2 and #6) identified with weight loss. Failure to implement nutritional interventions consistently resulted in Resident #2 and #6 experiencing severe weight loss. Findings include: Review of the facility policy titled "MONITORING RESIDENTS WITH IMPAIRED NUTRITION AND NUTRITIONAL RISK" occurred on 03/13/14. This policy, dated February 2013, stated, "POLICY: The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight, protein levels and hydration status unless the resident's clinical condition demonstrates that this is not possible. PROCEDURE: 1. Residents with impaired nutrition or nutritional risk may be identified by nursing, dietary and other members of the care plan team. . . . 5. The DDS [Director of Dietary Services] or designee will review resident weights monthly or more often to identify residents with significant weight loss/gain (5 percent [%] in 30 days, 7.5 percent in 90 days or 10 percent in 180 days) or insidious weight loss or gain. Insidious weight loss or gain refers to gradual unintended, progressive weight loss or gain over time. . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10%	F 325	F 325 Resident # 6 and # 2 will have their individual needs address by documenting the acceptance of fortified foods, physician ordered house supplements, and resident specific snacks. The DDS will review the residents on nutrition risk receiving fortified foods and document the acceptance of the fortified food item(s) weekly and prn to determine if the resident is accepting the food intervention. The dietician will reevaluate each of these two residents on 4/15/14 and provide us with an updated nutrition at risk monitoring list and follow up by writing a progress note on each resident medical record. For resident 2, we will use only the wheelchair scale for weighing and care plan update to inform staff. System change: Nursing will document physician ordered supplement intake on the EMAR. Dietary will document fortified foods consumed at meals in point of care documentation.	4/28/14

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F 325	Continued From page 28 - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. Physician's orders included a nutritional supplement at 3:00 p.m. and 8:00 p.m. (initiated on 01/31/14). The annual Minimum Data Set (MDS), dated 01/24/14, identified the resident required extensive assistance for eating. The Care Area Assessment (CAA), dated 01/24/14, stated, "[Resident #6] is losing weight. She receives supplements and enhanced cereal daily." Resident #6's current care plan stated: "Focus: The resident has an ADL [Activities of Daily Living] self care performance deficit R/T [related to] Dementia e/b [evidenced by] needs assist of one to two with adl's . . . Interventions: Eating: Resident requires reminding and assistance to eat . . . Focus: The resident has nutritional problem or potential nutritional problem has had 10% weight loss . . . *Give resident fortified foods per dietary plan. House supplement with meals . . . *Scheduled resident specific snack/food intervention 3PM and HS [hour of sleep] *Scheduled resident specific snack/food intervention offer snack between meals if res [resident] eats less that 50% of breakfast lunch or supper." Review of Resident #6's weights identified the following: *07/10/13 - 115.5 pounds *08/14/13 - 111 pounds *09/18/13 - 110 pounds *10/23/13 - 103.5 pounds - 12 pound weight loss in 3 months (10.4% loss) *11/27/13 - 103 pounds	F 325	Dietician will reevaluate both residents on 4/15/14 and each will continue to be followed during the nutrition risk committee meeting monthly. A report in PCC will be generated to list residents with weight fluctuation/loss of 5% in 30 days or 10% in 180 days have the potential to be affected in this area. All resident that trigger will be assessed by the dietician. By educating our staff an auditing our care plan interventions for nutritionally fortified food interventions, house supplements, and needed snacks documentation we will prevent other residents from potential weight fluctuations/loss. Nursing staff will be educated on 3-14-2014 on the procedure titled Monitoring residents with impaired nutrition and nutritional risk with a focus on the need to obtain weekly weights and the need to reweigh if more than a 3 pound weight change from the previous weight. Also to document physician ordered supplements and dietary ordered fortified foods.	

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F 325	Continued From page 29 *12/25/13 - 103 pounds *01/29/14 - 100 pounds - 15.5 pound weight loss in 6 months (13% loss) Review of Resident #6's dietary progress notes identified the following: *07/16/13 - "Wt [weight] review 115.5# [pounds] 5% [down] 3 mos [months]. Intakes vary 0-100% - fluid intake [less than] 800 ml [milliliters] average at meals . . . Offer [high] cal [calorie] when eating. No aggressive support planned." *08/20/13 - ". . . 111# 3% [loss] 6 mo [months] 9.8% 3 mons. [months] gradual [decrease] . . . Staff cue refuses to be fed. Independent in choices. Try enh [enhanced] pudding or [high] cal ice cr [cream] for desserts." *09/17/13 - ". . . Wt. 110# 8% [decrease] 6 months . . . Supplements offered . . . Offering enhanced items & [and] supplements 4 x/day . . . Continue to monitor . . ." *10/15/13 - ". . . Wt 107.5# Continues to have wt loss . . . Continues to receive enh items & suppl [supplements] QID [four times a day] . . . Encourage suppl especially at meals & snacks." *11/19/13 - ". . . staff are assisting more at meals . . . Receives supplements at meals 3PM . . . Wt. stable 106# . . ." *02/18/14 - ". . . continues to have variable intake at meals . . . averaging 50%. Offered 5 - 6oz [ounces] health shakes . . . wt is stable 105# . . ." *03/12/14 (during the survey) - ". . . no longer gets supplement at meal time per physician, want to see if intake improves, she receives chocolate milk in place . . . Continues to get enhanced cereal at breakfast, does not care for it much, prefers toast with jelly . . . if weight loss occurs, will go back to offering supplement with meal . . ." [supplements changed from five times a day to twice a day on 01/31/14].	F 325	Dietary staff will be educated on 4-14-2014 on the procedure titled Monitoring residents with impaired nutrition and nutritional risk and Fortified Foods with a focus on the need to document fortified foods. System change: Bath scales will no longer be used. All residents who can walk onto the wheelchair scale or their wheelchair fits on the scale will be weighed on this scale. All others will be weighed on lift scale. An audit tool will be developed to monitor resident's weights. If a residents weight is off by three pounds or more staff must reweigh the resident immediately. And to monitor the acceptance of fortified foods by dietary and physician ordered house supplements by nursing staff. The audits will be completed weekly x 4 weeks, then monthly x 2 months. Staff development or designee will complete audits. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	

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Observations of meal and supplement intake by Resident #6 showed the following:
*03/11/14 at 8:55 a.m. - a glass of whole milk, cup of coffee, glass of orange juice, one half of a banana, two slices of toast with peanut butter, and no enhanced cereal. Resident #6 consumed less that 51% of the meal.
*03/11/14 at 12:25 p.m. - mashed potatoes, carrots, ground meat, one half of a slice of bread, bread pudding, and a glass of cranberry juice. Resident #6 consumed less that 51% of the meal.
*03/11/14 at 5:00 p.m. - per interview with a staff nurse (#8), Resident #6 consumed 75% of a 6 oz supplement drink about 3:15 p.m.
*03/12/14 at 8:25 a.m. - hot cereal with cream, one slice of toast with jelly, a glass of grape juice and a glass of water. Resident #6 consumed less than 25% of the meal.
*03/12/14 at 10:45 a.m. - A nurse (#8) gave the resident a 6 oz strawberry supplement shake. The nurse stated, "She likes strawberry."
*03/12/14 at 12:05 p.m. - chocolate milk, jello, ground Swiss steak, mashed potatoes with butter, beets, and one half of a slice of bread. Resident #6 consumed less that 25% of the meal.
*03/13/14 at 8:20 a.m. - hot cereal with cream, two slices of toast with peanut butter, a scrambled egg, milk [not chocolate] and water. Resident #6 consumed the two slices of toast except for the crust and none of the hot cereal or egg. The dietary staff member had not recorded the percentage of consumption.

During an interview on 03/12/14 at 9:25 a.m., a dietary staff member (#19) stated there is no place to document how much fortified foods a resident has consumed during a meal. If a resident consumes less than 50% of a meal, she

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writes the resident's name a piece of paper, gives it to the nurse, and someone gives the resident a supplement in between meals.

Failure of the facility to re-assess Resident #6's continued weight loss, implement dietary interventions the resident prefers, and document or communicate the amount of fortified foods consumed, resulted in Resident #6 experiencing a severe weight loss of 15.5 pounds in 6 months.

- Review of Resident #2's medical record occurred on March 10-13, 2014. Resident #2's medical diagnoses included history of transient ischemic attacks (TIAs), left hemiparesis, muscle weakness, and viral pneumonia (which required hospitalization in October 2013).

Resident #2's quarterly MDS, dated 01/08/14, identified limited assistance with eating and weight loss (not physician prescribed).

Resident #2's current care plan stated:
"Focus: The resident has an ADL self care performance deficit R/T CVA [cerebral vascular accident] E/B left sided weakness . . . Eating: Resident requires reminding, prompting, cueing to eat slowly, assistance to eat. Divided plate used. Provide milkshakes or liquid food or nourishments when resident refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or a mug . . . Focus: The resident has unplanned weight loss R/T poor food intake E/B decline in cognitive ability, dental or oral problems . . . Give fortified menu. Encourage slower eating by providing food in separate bowls, cueing, etc. to decrease risk of aspiration . . . ."

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F 325	Continued From page 32 Review of Resident #2's weights showed facility staff weighed the resident using several different scales (chair/wheelchair scale, bath scale, mechanical lift scale, and standing scale) to record his weight since admission. Resident #2's weights (using a chair/wheelchair scale) included: 09/15/13 - 179 pounds 11/03/13 - 170 pounds (The facility weighed Resident #2 two times in October 2013 upon return from the hospital using a different type of scale.) 12/15/13 - 163 pounds - 15 pound weight loss in 3 months (9% loss) 01/19/14 - 158.5 pounds 02/09/14 - 166.5 pounds 03/09/14 - 160.5 pounds - 18.5 pound weight loss in 6 months (10% loss). Review of Resident #2's Nutrition Assessments, dated 09/17/13 and 10/15/13, identified a weight goal of "180-190" pounds. The facility failed to complete additional Nutrition Assessments after October 2013 even though Resident #2 continued to lose weight. Resident #2's "Dietary Profile," dated 02/11/14, identified the resident received a regular, dental soft diet and an eight ounce nutritional supplement in the "PM, HS [before hour of sleep], and with meals." Review of Resident #2's dietary/nutritional notes, stated, *10/15/13 - "Nut [Nutritional] Risk 183 #. Returned from hospital yesterday. Had pneumonia . . . ." *01/21/14 - "Nurition [sic] risk has had significant wt [weight] loss in 4 months since admit. Eats quickly so was pureed but did not like it and did not eat well. Diet upgraded to dental soft. Ground	F 325		

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meats provided. Food is served in divided plate. Meal intakes have improved slightly. He was also moved to a table with all men with staff assistance. Staff cue to slow down. Continues to receives supplements and 2 snacks at 3 p.m. and HS. Enhanced cereal at breakfast . . . Prefers sweet foods . . . ."
*02/18/14 - "Nutrition risk . . . has variable intake at meals. He feeds himself after meal set up. staff cue and assist if needed . . . Wt is 162 [pounds] . . . Overall has lost 7% in 3 months. Offered HS sandwich and supplements 5 [times] per day for added nutrition . . . Supplements at meals and 3 p.m. taken well. Usually sleeping HS so does not take supplement or snack. Follow another month on nutrition risk.

Observations of meal intakes for the breakfast meal on 03/11/14 at 8:45 a.m. and the lunch meal on 03/11/14 at 12:45 p.m. identified Resident #2 consumed 51%-75% of both of these meals. Observation showed the facility failed to provide any supplements during these meals.

During interview on the afternoon of 03/12/14, an administrative nurse (#1) stated the facility discontinued offering meal time supplements "a few weeks" ago on the recommendation of a corporate consultant. An administrative nurse (#1) stated the corporate consultant recommended to only provide supplements if a resident consumed less than 50% of either breakfast, lunch, or supper.

Review of Resident #2's meal intake logs dated March 01-12, 2014, identified the resident consumed less than 25% of the meal on three occasions (the lunch and supper meal on March 3, supper meal on March 6, and the supper meal

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F 325	Continued From page 34 on March 11), and staff members failed to provide Resident #2 with a snack/food intervention. During interview on the afternoon of 03/12/14 with a dietary staff member (#2), identified dietary staff provides a 3 p.m. house supplement (also known as a "Health Shake") for nursing staff to give to Resident #2. The dietary staff member (#2) stated the facility stopped providing the 8 p.m. snack related to Resident #2 being in bed and/or sleeping at that time. Review Resident #2's house supplement documentation records for the 3 p.m. supplement from March 01-12, 2014, identified the facility offered the house supplement on only one occasion (March 12). The facility failed to establish a system to ensure Resident #2 is weighed with the same scale each time, comprehensively assess his continued weight loss, implement existing dietary interventions (mealtime supplements and snacks at 3 p.m. and 8 p.m.), and document the amount of house supplements offered and consumed. These failures resulted in Resident #2 experiencing a severe weight loss of 18.5 pounds in 6 months.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy review, the facility staff failed to offer fluids	F 327		

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F 327	Continued From page 35 to 3 of 5 sampled residents (Residents #7, #8, and #10) who required extensive or total assistance for eating. Failure to offer fluids during cares increased the residents' risk of dehydration. Findings include: Review of the facility policy titled "Hydration Of Residents" occurred on 03/13/14. This policy, dated September 2012, stated, "PURPOSE, To maintain hydration status of residents . . . PROCEDURE . . . 7. Fresh water will be available to the residents at bedside unless contraindicated . . . Staff will be trained on the importance of hydration and the signs and symptoms of dehydration. . . ." - Review of Resident #7's medical record occurred on March 11-12, 2014 and diagnoses included organic brain damage and Parkinson's disease. The quarterly Minimum Data Set (MDS), dated 02/22/14, identified short and long-term memory problems and extensive assistance required for eating. The current care plan stated, ". . . EATING: Resident requires cueing and physical assistance to eat. . . ." Observations of Resident #7's cares identified the following: * 03/11/14 at 9:31 a.m. - Two Certified Nursing Assistants (CNAs) (#3 and #4) transferred the resident from his wheelchair into bed and checked the resident's incontinent product. The CNAs (#3 and #4) failed to offer Resident #7 fluids during cares. * 03/11/14 at 12:56 p.m. - Two CNAs (#3 and #5) transferred the resident from his wheelchair into bed and changed his incontinent product. The CNAs (#3 and #5) failed to offer Resident #7	F 327	F 327 For residents 7, 8, and 10 education was provided to direct care staff on the importance of offering fluids with cares. All residents who require assistance with ADL's have the potential to be affected in this area. By educated our staff and auditing our systems we will prevent other residents from being affected in this area. On 4/14/14, all staff will be educated on the procedure titled, "Hydration of Residents" with a focus on the importance of offering fluids to residents during cares and at activities. System change: A pitcher of water or juice with cups will be placed in activity room. Audits will be completed along with ADL audit to be sure fluids are offered with cares weekly x 4 weeks and then monthly x 2 months. The audit is being completed on the audits for F241 and F323. The DNS or designee will be responsible for the audit. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14

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F 327	Continued From page 36	F 327		

fluids during cares.
* 03/11/14 at 3:46 p.m. - Two CNAs (#6 and #7) changed the resident's incontinent product, transferred him into his wheelchair, and transported the resident to the activity room. The CNAs (#6 and #7) failed to offer Resident #7 fluids during cares.
* 03/12/14 at 9:28 a.m. - A nurse (#8) changed the resident's dressing to his right buttock. The nurse (#8) failed to offer Resident #7 fluids during her interaction with the resident.
* 03/12/14 at 11:45 a.m. - Two CNAs (#3 and #9) changed the resident's incontinent product and transferred him into his wheelchair. The CNAs (#3 and #9) failed to offer Resident #7 fluids during cares.

- Review of Resident #10's medical record occurred on March 12-13, 2014 and diagnoses included dementia, contracture of joint, and stiffness of joints. The quarterly MDS, dated 03/05/14, identified total assistance required for eating. The current care plan stated, ". . . EATING: Resident requires total assistance to eat . . . The resident has depression R/T [related to] dementia E/B [evidenced by] flat affect, poor oral intake. . . ."

Observation on 03/12/14 at 3:55 p.m. showed two CNAs (#10 and #11) changed the resident's incontinent product, transferred her into her wheelchair, and transported the resident to the activity room. The CNAs (#10 and #11) failed to offer Resident #10 fluids during cares.

- Review of Resident #8's medical record occurred on March 12-13, 2014. Diagnoses included dementia, legal blindness, and a history of urinary tract infections (UTIs). The quarterly

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F 327	Continued From page 37 MDS, dated 02/22/14, identified the resident required extensive assistance of person for eating. Resident #8's current care plan stated, "Focus: The resident has dehydration or potential fluid deficit R/T [related to] Poor intake e/b [evidenced by] not always drink [sic] her fluids at meals . . . Interventions: Offer drinks during resident interactions." Observation on 03/12/14 at 5:15 p.m. showed Resident #8 lying on her bed. Two CNAs (#10 and #11) transferred the resident into a wheelchair, brushed her hair, and transported her into the dining room at 5:25 p.m. The CNAs failed to offer Resident #8 fluids with cares and observation showed no fluids available on the dining room table for the resident.	F 327		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily menus, and staff interview, the facility failed to meet the nutritional needs of residents by not serving correct portion sizes during 1 of 3 observations (lunch on 03/12/14) of tray line service. Failure to follow specified portion sizes as identified in the	F 363		

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F 363	Continued From page 38 facility's menu may result in inadequate nutritional intake, and potential weight loss. Findings include: - Observation of lunch tray line service occurred on 03/12/14 at 11:55 a.m. A dietary staff member (#18) identified #16 (1/4 cup/2 ounce) serving scoops for the ground meat, pureed meat, and pureed beets. The menu identified a three ounce portion for the ground and pureed meat, and a 1/3 cup portion for the pureed beets. The dietary staff (#18) identified the slotted scoop being used for the beets as a smaller portion than required and she would heap the amount served to compensate. The menu identified a 1/2 cup portion. As tray line service progressed another staff member (#19) assisted with tray line. This staff member (#19) used a level scoop or less when dishing beets. During an interview on 03/13/14 at 8:30 a.m., an administrative dietary staff member (#2) identified staff should have used a #12 (1/3 cup/3 ounce) scoop for serving the ground meat, pureed meat, and pureed beets. This staff member (#2) also identified dietary staff should have used the 1/2 cup slotted serving utensil for the beets. Refer to F 325.	F 363	F 363 No residents were identified as being affected during the survey process. Any resident that consumes meals by mouth have the potential to be affecting by this practice. By educated our staff an auditing our system we will prevent other residents from being affected in this area. On 3/18/14, a Mandatory education for dietary staff on the importance of using the correct spoon to provide the proper serving size by Kathy Larsen, Registered Dietician. Audits will be completed to insure that residents are using the proper serving size spoon and are being served the proper portion of foods weekly x 4 weeks and monthly x 2 months. Dietary Manager or designee will responsibly for the completion of the audits. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training. Staff T.t.-adm 4/21/14 dd	4/28/14
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced	F 366		

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F 366	Continued From page 39 by: Based on observation and staff interview, the facility failed to provide alternates of similar nutritive value to residents who did not like a portion of the meal served during 1 of 1 observation of noon meal tray line (03/12/14). Failure to provide residents a substitute places residents at risk of malnutrition and weight loss. Findings include: - Observation of tray line occurred on 03/12/14 at 11:55 a.m. The meal provided included Swiss steak (including ground and pureed), mashed potatoes, and beets (including pureed). Above the tray line staff kept a board with listings of resident likes and dislikes. This board identified three residents did not like beets. Observation showed no alternate vegetable available on the steam table. Of the two residents who did not like beets, dietary staff (#18) provided a resident Swiss steak and mashed potatoes without a vegetable. Staff provided another resident Swiss steak, mashed potatoes, and beets. An unidentified serving staff member returned indicating the resident did not like beets. Neither of these residents received another vegetable. A dietary staff (#18) identified one resident would not eat the Swiss steak. The dietary staff (#18) attempted to send the resident a pancake, but then indicated the facility did not have pancakes. The dietary staff (#18) sent the resident a banana, mashed potatoes, and beets for the noon meal. During an interview on 03/13/14 at 8:30 a.m., an	F 366	F 366 No residents were identified to be affected in the survey report. Any resident that consumes meals by mouth have the potential to be affected by this practice. By educating our staff an auditing our system we will prevent other residents from being affected in this area. System Change: The menu now has an alternative options listed. Dietary has provided a list of alternative items that are available 24 hours a day. On 4/14/14, a Mandatory dietary meeting held to provide education on the change to the menu system, as well as, the importance of providing foods to residents that they prefer. An audit tool will be completed to ensure that residents are offered preferred foods and that the menus continue to offer alternative meals and items. The Audit will be completed by ADNS or designee. Audits will be completed weekly x 4 weeks and monthly x 2 months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14

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F 366	Continued From page 40 administrative dietary staff member (#2) identified staff should have provided green beans for the residents who dislike beets. This same staff member (#2) also explained there were pancakes available for the resident who would not eat Swiss steak, however staff were unable to locate the pancakes.	F 366	F 372 No residents were identified to be directly affected in the survey process. Garbage dumpster lids fit and close properly. Lids are in place and closed. All residents have the potential to be affected by this practice. By educated our staff an auditing our system we will prevent other residents from being affected in this area. On 4/14/14, a Mandatory ALL staff in-service was held to educate staff on the importance of closing the garbage dumpster lids to prevent pests or rodents from harboring. An audit tool will be developed to monitor the dumpster lids. The Maintenance department or designee will be responsible for the completion of the audit. The audit will monitor dumpsters daily to insure lids are closed. Audits will be completed 3-5 times per week for the first two weeks, then weekly for four weeks, and then monthly X two months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing and/ or training.	4/28/14
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain garbage receptacles in a manner to prevent infestation in 1 of 2 dumpsters on 2 of 3 days of observation (03/11/14 and 03/13/14). Failure to close the dumpster lid increases the potential to provide harborage of pests and rodents. Findings include: - Observation on 03/11/14 at 8:40 a.m. showed one of five dumpster lids open. - Observation on 03/13/14 at 8:17 a.m. showed the one dumpster open. - A dietary tour on 03/13/14 at 10:05 a.m. completed with an administrative dietary staff member (#2), showed the one dumpster remained open. The dietary staff member (#2) identified staff know to close the lid.	F 372		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 41 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 431	F0431 No residents were identified to be directly affected in the survey process. All residents who receive refrigerated medication have the potential to be affected by this practice. By educating our staff and auditing our system we will prevent other residents from being affected in this area. All refrigerated medications listed have been replaced, except the eye drop that was discontinued. System change: A new refrigerator was purchased to ensure the temperature control. On 4/14/14, Nursing staff was educated on the appropriate temperature range for storing medication. That range is (36-46 degree) if temperature falls out of range nursing department will adjust temperature to get in range and during that time the medication will be moved to an alternate refrigerator that is within that appropriate range. An audit tool will be developed to monitor the temperature range and staff action take if outside of the desired temp range. Nursing department or designee will monitor temperature 3-5 times per week for one week, then weekly x 4 weeks, then monthly x 2 months. The	4/28/14

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F 431	Continued From page 42 facility policy, and staff interview, the facility failed to store all medications under proper temperature controls in 1 of 1 medication refrigerator. Failure to maintain the refrigerator temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "Insulin Storage Recommendation" occurred on 03/13/14. This policy, dated 2013, stated, "Vials, Unopened, Refrigerated (36 [degree] F [Fahrenheit] to 46 [degree] F), Opened, Refrigerated (36 [degree] F to 46 [degree] F). . . . Do not use any insulin products that have been frozen." Observation of the medication room on 03/13/14 at 8:48 a.m. showed the refrigerator to be 32 degrees F. Review of the "Refrigerator Temperatures" logs showed the following. * March 2014: 30 degrees F five days, 32 degrees F five days, and 34 degrees F one day of 12 completed. Staff documentation for one day could not be read * February 2014: 30 degrees F six days, and 32 degrees F 13 days of 20 completed. * January 2014: 30 degrees F nine days, 32 degree F 11 days, and 34 degrees seven days of 30 completed. * December 2013: 30 degrees F three days, 32 degrees F 11 days, and 34 degrees seven days of 29 completed. * November 2013: 30 degrees F eight days, 32 degrees F 11 days, and 34 degrees four days of 27 completed. Staff documentation for one day could not be read and one day the temperature	F 431	audit report will be reviewed at QA meeting to determine if there is need for further auditing and/or training.	

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F 431	Continued From page 43 showed 30 degrees and a recheck of 32 degrees. * October 2013: 30 degrees F four days, 31 degrees F one day, 32 degrees F 20 days, and 34 degrees three days of 30 days completed. Further review of the medication refrigerator showed facility staff stored the following medications in the refrigerator: * Two unopened insulin vials, one each Novolin 70/30 and Levemir insulin. * 12 opened insulin vials, two Novolin 70/30, three Lantus, three Levemir, and four Novolog, * Zioptan (tafluprost ophthalic solution) stated, "store 36 [degrees] - 46 [degrees]" * One prefilled syringe Lorazepam. * Box of Boscolax, and * Two boxes Acetaminophen Suppositories. During an interview, on the morning of 03/13/14, an administrative nursing staff member (#1) identified the nurses know what the temperature of the refrigerator should be. He indicated the nurses have the policy titled "Insulin Storage Recommendation" available to them. When the temperatures are out of range the temperature of the refrigerator should be adjusted. The documented temperatures registered lower than the recommended temperatures on 119 of 136 days reviewed. The facilities failure to maintain refrigerator temperatures between 36-46 degrees F had the potential for the medication to freeze and lose their efficacy/potency.	F 431		